Supreme Court, U.S.
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No. _____

In The

Supreme Court of the United States

USHA VAKHARIA, M.D.,

Petitioner,

v.

SWEDISH COVENANT HOSPITAL, AMERICAN SOCIETY OF ANESTHESIOLOGISTS, et al.,

Respondents.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

I. In a national origin, age, gender and denial of fair hearing discrimination case, is it a proper summary judgment standard for a federal court to defer to the judgment of a hospital "peer review" committee when evidence of discrimination and comparative evidence relating to patient care of other anesthesiologists in the department was excluded and it resulted in the removal of all female Asian anesthesiologists.

II. When a complaint alleges a conspiracy between a national association of anesthesiologists and the hospital to eliminate foreign born medical graduates from hospital staff through a phoney "peer review," but depositions are denied of individuals who drafted the ASA report which formed the pretextual basis for termination, and no ability was granted to demonstrate that the ASA had been involved in similar activity with respect to other area hospitals, are such denials appropriate?

III. Is denial of leave to amend the complaint appropriate when defamation counts are based upon belated false reporting of alleged improper medical care above and beyond the findings of a peer review committee to state and federal authorities years after the bringing of the instant lawsuit?

IV. Is it proper to refuse to consider the 12m statement of uncontested facts to which the defendants filed no response, and which the court ignored, including the affidavit of plaintiff's expert witness anesthesiologist to the effect that errors revealed on the face of medical charts by white "senior" anesthesiologists were substantially more serious than those errors "alleged" of junior female Asian anesthesiologists on the grounds that such an opinion should

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have been expressed in the hospital ad hoc hearing, when the hospital charts for "senior" anesthesiologists were not available until years later through discovery, and the ad hoc hearing had barred testimony regarding discrimination, even though medical peer evaluation is intrinsically a comparative process?

V. Whether it is proper to apply a test such as that announced in *Alexander v. Rush North Shore Medical Center*, 101 F.3d 487 (7th Cir. 1996) to determine ability to raise Title VII and Age Discrimination in Employment claims when a member of the hospital staff maintains an employment relationship based on her exclusive hospital-based practice and is contractually protected by the medical staff's bylaws to be free from sex, race, color, creed or national origin discrimination under all federal and state laws (including title VII and ADEA) and what tests need to be applied to evaluate the relationship?

LIST OF RESPONDENTS

Swedish Covenant Hospital
Nancy Loeber, M.D.
Demetrius A. Trakas, M.D.
Michael J. Plunkett, M.D.
Loren Dardi, M.D.
Johanna Chookaszian, M.D.
Marshall S. Salkin, M.D.
Walter I. Baba, M.D.
Alvin Somberg, M.D.
Paul Larson, M.D.
Roberto Espinosa, M.D.
S. Yelda, M.D.
M. Barry Kirshenbaum, M.D.
G. Christopoulos, M.D.
Howard Konowitz, M.D.
James B. McCormick, M.D.
Arthur R. Peterson, M.D.
Edward A. Cucci
Charles Vacanti, M.D.
Louis Blancato, M.D.
Ronald H. Wender, M.D.
Tun Myint, M.D.
Richard Swedberg
Craig E. Anderson
Isolde Anderson
Robert E. Edlen
Milton B. Engebretson
Myrtle A. Erickson
Paul E. Larson
American Society of Anesthesiologists

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V. Whether it is proper to apply a test such as that announced in *Alexander v. Rush North Shore Medical Center,* 101 F.3d 487 (7th Cir. 1996) to determine ability to raise Title VII and Age Discrimination in Employment claims when a hosptial by contract embodied in hospital by laws incorporates rights against discrimination, but the hospital entirely controls through medical credentialling the ability of an anesthesiologist to practice her employment, and may destory such ability to be employed by reporting to state and federal authorities alleged issues of medial competence?..... 21

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PETITION FOR WRIT OF CERTIORARI

Petitioner Usha Vakharia, M.D., respectfully requests that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Seventh Circuit.

OPINIONS BELOW

The opinion and judgment of the United States Court of Appeals for the Seventh Circuit entered on September 9, 1999, rehearing denied, December 7, 1999, appears at 190 F.3d 799 (7th Cir. 1999) and is attached as App. 1. The opinion and judgment of the United States District Court for the Northern District of Illinois entered on the docket on November 20, 1997, amended December 9, 1997 appears at 787 F.Supp. 633 (N.D. Ill. 1997) and is attached as App. 23. The order of denial of the petition for rehearing and the petition for rehearing and correction with suggestion for rehearing en banc is attached as App. 57.

JURISDICTION

Jurisdiction in the United States District Court was pursuant to Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000(e)-(f)(3) for Counts I and VII, the Age Discrimination Act of 1967 (ADEA) as amended, 29 U.S.C. § 626(c). For Count II jurisdiction existed under 42 U.S.C. § 1981 and 28 U.S.C. §§ 1331 and 1343. For Count III, 42 U.S.C. §§ 1981 and 1985, 28 U.S.C. §§ 1331 and 1343, and the pendant jurisdiction of the Court for Count

IV. For Count V, jurisdiction in the district court was under §§ 1981 and 1985, and 42 U.S.C. § 1395dd and 42 U.S.C. § 2000d, and 28 U.S.C §§ 1331 and 1343. Jurisdiction under Count VI was under 15 U.S.C. §§ 1 and 2, and 28 U.S.C. § 1337.

The Court of Appeals had jurisdiction pursuant to 28 U.S.C. § 1291.

The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1254(1) and Supreme Court Rules 10(a) and (c).

The Respondent, Swedish Covenant Hospital, is an Illinois corporation, with its principal place of business in Illinois. The respondent American Society of Anesthesiologists is a New York corporation with its principal place of business in Illinois. All of the other respondents are natural persons who are citizens of Illinois except for Nancy Loeber, M.D., a citizen of Rhode Island, Louis Blancato, M.D., a citizen of New York, Charles Vacanti, M.D., a citizen of New York, and Ronald H. Wender, M.D., a citizen of California. Jurisdiction was not based on diversity of citizenship.

STATEMENT OF THE CASE

Dr. Usha Vakharia is a board certified anesthesiologist who was on the medical staff of Swedish Covenant Hospital (hereinafter Hospital) for fifteen years until she was summarily suspended on June 30, 1989. In all of those years at the Hospital, she was not the subject of any disciplinary action or proceedings of any kind before any

body and was a defendant in one malpractice action which was dismissed after a jury deliberated for nine minutes. In 1984-1985, she was also the Secretary of the Hospital Medical Staff and for a period of nine months, the acting Director of the section of Anesthesiology.

In late 1983, when respondent Dr. James McCormick became the President of the Hospital, the Anesthesiology Section consisted of four anesthesiologists, two female Asian Americans, one male Asian American and one female of European descent, all of whom were foreign medical graduates. Dr. Sudarshan Sexena, a female Asian American, was the director. In early 1984, the female of European descent retired and Dr. Sexena was forced out by Dr. McCormick. Dr. Vakharia was appointed as acting Director by the Chairman of Surgery who was also the Head of the Anesthesiology section. To alleviate the staff shortage, Dr. Vakharia recruited a female Asian American anesthesiologist who had previously worked at and was known to the Hospital. Dr. Vakharia then applied for the position of Director but was never interviewed. Instead, Dr. McCormick appointed Dr. Nancy Loeber, a female white native-born American, who had applied for a staff position as Director of the section. Dr. Loeber had no previous credentials for this position and began her duties in April 1985.

With Dr. Loeber's appointment, the structure of the section began to change. Dr. Loeber began recruiting white native born Americans with an intent to replace the female Asian Americans. She recruited one in 1985, two in 1986 (one resigned in 1987) and one in 1987, all of

whom were white native-born Americans. In 1986, anesthesiology was upgraded to department status and Dr. Loeber was named Chairman.

The practice in the anesthesiology department had always been to share the workload and the on-call service on an equal sharing basis. This practice continued under Dr. Loeber but the caseload (and as a result earnings) per anesthesiologist decreased because of the overstaffing. In September 1987, in response to Dr. Loeber's prior suggestion to the whole department, Dr. Vakharia reclassified her malpractice insurance to part-time status. This status still allowed her to receive the full complement of her share of the workload, but reduced her malpractice premiums by half.

But Dr. Loeber had other ideas and began to systematically reduce the assignments to Dr. Vakharia to dramatically reduce Dr. Vakharia's workload. In January 1988, Dr. Loeber created a class of "senior" and "junior" anesthesiologists in violation of the medical staff bylaws, in April 1989 removed board certification as a requirement for "senior" status, classified all three female Asian anesthesiologists to "junior" status and deemed that henceforth the "senior" anesthesiologist would have preference over all of the workload of the department. Along with the reduction of assignment of cases, the case mix was also changed. Complex and more remunerative cases were assigned to the "seniors" and "juniors" received low value cases. However, if complex cases involved a lower payment method such as Medicaid, it would be assigned to the "juniors." During April-June 1988, she wrote to the "juniors" advising them to look for other employment and suggested names of employment agencies on the

premise that the workload could only support four to five anesthesiologists. In fact, the workload of the department remained virtually unchanged during this period and increased in 1987 and 1988.

After Dr. Vakharia's complaints to Dr. Loeber when unresolved, she complained to the Medical Executive Committee (hereinafter, MEC) of this discriminatory treatment. Dr. Loeber then claimed that the decrease in the assignment of cases was due to a decrease in the workload of the department and "quality of care" problems of Dr. Vakharia, both of which were untrue. Dr. Vakharia met with Dr. McCormick who advised her to retire on the threat of having her dirty laundry aired in public.

In order to justify her claims Dr. Loeber then researched past anesthesia records of Dr. Vakharia, some dating back several years, and created a list of sixty-six cases on which she claimed that Dr. Vakharia provided substandard care. Dr. Vakharia offered to respond to these claims, but Dr. Demetrius Trakas, president of the medical staff, advised her that no response was necessary if Dr. Vakharia chose to leave the hospital. Dr. Vakharia then wrote to the MEC that she was willing to respond if required to do so, but the MEC never responded. Nurses and nurse anesthetists were directed not to file incident reports on the "seniors," and one such "senior" report from 1987 was destroyed. The matter simmered for some time and in retaliation, Dr. Loeber removed Dr. Vakharia from the on-call schedule and refused to assign any cases to her. Dr. Vakharia then approached the physicians on

the medical staff and obtained direct referrals of their cases.[1]

Confronted with an increasing workload for Dr. Vakharia, Dr. McCormick then attempted to prevent the surgeons from referring their cases to Dr. Vakharia. Racist remarks were made by many physicians in the Hospital, including the Chairman of OB-GYN, the Director of Orthopedics and Dr. Loeber. Also, Dr. Loeber then began to harass and intimidate Dr. Vakharia by denying her a key and access to the anesthesia office where they stored anesthesia and emergency supplies, requiring her to sit in the hallway and use the nurses' room for her coat and purse. On one occasion, a plastic tubing on a nitrous oxide tank was deliberately cut by someone to create a hazardous situation on Dr. Vakharia's cases.

In October 1988, the Hospital retained an outside reviewer to review Dr. Loeber's pre-selected cases on Dr. Vakharia, but he later withdrew. In his deposition, the reviewer indicated that as all quality of care review is a

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[1] Despite footnote 1 of the Seventh Circuit opinion, Dr. Vakharia received most referrals from American-born medical graduates not foreign-born medical graduates. Nor did she ever initiate her own review of records of other anesthesiologists, an impossibility as such records were unavailable until production in discovery. The Seventh Circuit also incorrectly attributes the selection of sixty-six cases to review conducted by the Quality Assurance Department. Dr. Loeber's deposition indicated she pulled the sixty-six cases for review after being directed to get additional cases by Dr. McCormick. Only one of the sixty-six cases had ever been the subject of a Quality Assurance Committee review (the 9 minute jury acquittal).

comparative process, he would not accept any assignment that would not review the entire department. The Hospital then retained the American Society of Anesthesiologists (hereinafter ASA) to review the quality of care of specific anesthesiologists and the structure of the department.

Dr. Ronald Wender and Dr. Louis Blancato conducted a two day review on behalf of the ASA. During their visit, they ostensibly reviewed a total of approximately two hundred medical records of all of the anesthesiologists, interviewed approximately thirty physicians and nurses on site, reviewed a vast amount of policy and quality of care manuals, personnel files and other Hospital documentation, and also observed several anesthesiologists providing anesthesia on cases. Although the anesthesiologists were told that they had to be present during the ASA visit, two "seniors" were not in the Hospital during the visit. Dr. Wender admitted that he relied upon the Hospital to identify cases for review. Quality Assurance Department monthly minutes disclosed many complications of the "seniors" which were not shown the reviewers. Also, a death in the operating room of a "senior" that should have been reported as a complication was not according to Dr. Wender. Dr. Wender has testified that they accomplished all of this on-site in their two day review and never removed any records from the Hospital premises. It is absolutely incomprehensible that they could accomplish most of this and review two hundred medical charts during this period.

The ASA submitted a report of this review to the Hospital on June 29, 1989 which criticized the care

provided by the three female Asian American anesthesiologists and a one line comment that the care provided by the white native-born American anesthesiologists met and was superior to the female Asian anesthesiologists. During his testimony at the hearing, Dr. Wender testified that he relied on the Hospital for many of the observations that he made in his report. During depositions, Dr. Blancato testified that he had no input into the report and relied on Dr. Wender to write the report. Dr. Wender testified he had no input except for the first draft of the report. All subsequent drafts and the final report were prepared and edited by Dr. Charles Vacanti, vice chairman of the ASA peer review committee, and Michael Scott, attorney for the ASA. The first draft, which was produced by Dr. Wender, contained no medical record analysis which was contrary to ASA policy and procedures. The six succeeding drafts, several of which including the final draft contained a medical record analysis section, but did not identify specific cases with specific complaints. The report lumped the evaluation of all three female Asian American anesthesiologists as a group and made critical comments about them and lumped the white native-born American anesthesiologists into another group but provided no analysis on their cases at all. The ASA report also stated that there was no doubt that Dr. Loeber wished to replace the three female Asian American anesthesiologists. But more importantly, Dr. Vacanti and Mr. Scott wrote the entire medical records section of the report without looking at any medical records as testimony indicates that none were sent to them. When Dr. Vakharia sought the depositions of Dr. Vacanti and Mr. Scott, they were denied.

In April 1989, Dr. Loeber resigned from the medical staff effective June 30, 1989. This resignation was not announced to the medical staff until mid-June 1989. On June 19, 1989, Dr. Vakharia re-applied for the Chairmanship of the Department. Dr. Vakharia was again not interviewed for the position.

On receipt of the report, Dr. McCormick summarily suspended the three female Asian anesthesiologists and advised them that if they resigned from the staff, the Hospital would not report their suspension to either the Illinois Department of Professional Regulation or the National Practitioner Data Bank and provide positive letters of recommendation to other Hospitals. The other two female Asian anesthesiologists accepted the conditions and did not seek a hearing as per the medical staff bylaws and were later rewarded with glowing letters of recommendation to other hospitals.

Dr. Vakharia sought a hearing in July 1989 under the bylaws which requires that a hearing for suspension be held no later than ten days after the receipt of a request for a hearing. When the Hospital did not convene the hearing, Dr. Vakharia sued in state court and the court ordered the hearing to commence on November 3, 1989. Prior to the hearing, the bylaws require the president of the medical staff, in consultation with the MEC, to appoint a hearing committee. Dr. Trakas created a panel of eleven physicians from whom the committee was to be selected. However, Dr. McCormick and Dr. Richard Swedberg, Chairman of the Board of Directors of the Hospital, along with Hospital counsel, Mr. Michael Callahan, met with Dr. Trakas and removed the names of all foreign-born and female physicians from consideration

and appointed the committee in violation of the bylaws. The committee chairman and several members were physicians who provided care on the same cases reviewed by the ASA for the Hospital and whose own care to patients could be questioned. Dr. Vakharia requested their resignation but the committee refused and Dr. Trakas did not replace them.

The committee set a very limited scope of the hearing despite Dr. Vakharia's objections and excluded the presentation of any evidence of discrimination and any comparative evidence relating to the care provided by any other anesthesiologist. This restriction applied to Dr. Vakharia only as the committee sought comparative comments from Dr. Wender who made bald statements asserting that the care provided by the three white native-born Americans was superior to the care provided by the three female Asian American anesthesiologists. Neither Dr. Vakharia nor her expert witness were allowed to review the records of the other anesthesiologists to rebut this testimony in violation of the bylaws. Indeed the ASA prevented Dr. Anthony Ivankovich, Chairman of Anesthesiology at Rush Presbyterian Medical Center, Chicago, from appearing as an expert witness on behalf of Dr. Vakharia, ostensibly because of a conflict of interest as he was a Director of the ASA.

The committee conducted nineteen days of hearings and compiled a record of 3130 pages and received thirty-eight exhibits from the Hospital and over two hundred from Dr. Vakharia. While the Hospital's presentation was spread over a four-month period, November 1989 to March 1990, Dr. Vakharia was required to present all of her evidence on four consecutive days in March. The

Hospital presented four witnesses, one of whom was Dr. Wender. Dr. Wender made many generalized statements criticizing the care of the female Asian anesthesiologists, but could not respond with specific complaints on specific cases. Dr. Loeber was another witness who testified regarding Dr. Vakharia's care. In response, Dr. Vakharia provided a written case-by-case analysis refuting all of Dr. Loeber and Dr. Wender's complaints and included medical literature and standards in support. Seventeen (most not foreign medical graduates) physicians also testified on Dr. Vakharia's behalf on her care that they would have no hesitancy in her treating themselves or their families. Dr. Vakharia also produced two expert witnesses who testified that Dr. Vakharia met the applicable standard of care. They also testified that Dr. Loeber was lying and that her complaints regarding Dr. Vakharia's care are contradicted by the medical records. Dr. Vakharia and her two experts were not allowed to review and present comparative evidence of the care provided by other anesthesiologists in the department.

The committee did not read Dr. Vakharia's case-by-case response that was offered in evidence, did not hold any meetings to review or discuss the evidence, nor did any member review it individually. The Hearing Officer consulted with the Hospital attorneys and drafted a report which was then signed by the committee. The report upheld the summary suspension with no possibility of future renewal of privileges. Dr. Vakharia appealed this recommendation to the Board of Directors and sought a new hearing on all issues including discrimination, but the Board adopted the recommendation and confirmed the summary suspension. The district court

found that the primary decision-maker in the process was the hearing committee.

Dr. Vakharia then filed a four-count complaint in federal court alleging discrimination and violation of the medical staff bylaws. Approximately two and a half years later, the Hospital began producing the medical records of the other anesthesiologists reviewed by the ASA so that a comparison could be made of their quality of care with that rendered by Dr. Vakharia. Dr. Vakharia's expert witness, Dr. Floyd Heller, Associate Professor of Anesthesiology, Rush Presbyterian St. Luke's Medical Center, Chicago, reviewed the medical records pertaining to the care rendered by the other anesthesiologists and Dr. Vakharia. On the basis of that review, Dr. Heller prepared an affidavit which was filed with Plaintiff's response to Defendants' Motion for Partial Summary Judgment. Dr. Heller's affidavit stated that the medical charts provided to the ASA on the three "senior" [white native-born American] anesthesiologists offered no basis for classifying them as either "high-tech" or rendering more sophisticated care than the "juniors" [three female Asian American anesthesiologists]. Very simple cases for the "seniors" were furnished to the ASA. The charts indicated that the "seniors" evidenced many, if not all, of what had been claimed as technical and judgmental errors on the part of Dr. Vakharia. The general level of care demonstrated by the "seniors" demonstrate more serious problems with anesthesia care that any of the problems allegedly related to Dr. Vakharia's care. After testifying at the ad-hoc hearing, Dr. Heller had concluded that the hearing of the ad-hoc committee was a sham. With respect to the only two patients of Dr. Vakharia

identified by the ASA report, Dr. Heller stated that the reports on those cases are at variance with the medical records. "Quality assurance is essentially a comparative and on-going process. . . . " Reports were to be prepared contemporaneously with the events described. The comparative process engaged in by the ASA was invalid. The Heller affidavit concluded:

> "I cannot find any valid medical non-discriminatory basis for the departures from the ordinary and customary practices as noted above, including without limitation, the dredging up of incidents long past the time they purportedly occurred and only after a claim of unfair and/or discriminatory treatment had been made by the target of the investigation for the testimony offered by Dr. Loeber or Wender, both as to the conditions of the patients and Dr. Vakharia's treatment, or the manner in which the ASA and the ad-hoc committee proceeded to consider the issues, such as the refusal to do a comparative analysis or consider the existence of a discriminatory motive."

Dr. Heller's deposition and affidavit provides support for the conclusion that, on some cases, Dr. Loeber was just plain wrong, she misread the charts, or thought that certain actions should have or should not have been taken and Dr. Heller disagreed.

Two and a half years after filing the complaint during discovery, Dr. Vakharia was first informed that the Hospital had belatedly made a report to the Illinois Department of Professional Regulation and National Practitioner Data Bank regarding Dr. Vakharia's quality of care. On review of these reports, it became apparent that the Hospital had

misrepresented and embellished the quality of care criticisms in the report sent to these agencies. Plaintiff promptly sought leave to amend the complaint to include additional counts for defamation, commercial disparagement and false reporting. The court denied leave to amend on June 13, 1993, indicating that "all roads lead to Rome."

The Defendants had filed a Motion for Partial Summary Judgment on six of the seven counts and a motion to dismiss the seventh count was pending before the court. Plaintiff filed a Rule 12(n)(3)(a) response to Defendants Rule 12(m) statement disputing virtually all of the facts relied upon by the Hospital and filed an additional Rule 12(n)(3)(b) statement for additional fact in support of her position. Plaintiff then filed a counter Motion for Partial Summary Judgment on the same counts and relied upon the previously submitted Rule 12(n) statements for her Rule 12(m) statement for her motion. Defendants did not respond to either of Plaintiff's Rule 12(n)(3)(a) or Rule 12(n)(3)(b) statements. The court did not address any of the facts submitted in any of the Plaintiff's Rule 12(n) statements and granted summary judgment to Defendants on all counts.

REASONS FOR GRANTING THE WRIT

This case presents several significant questions of law, the most significant of which is the first question – what constitutes "peer" review so as to bypass the use of discrimination and comparative evidence in a discrimination complaint.

The first issue:

I. In a national origin, age, gender and denial of fair hearing discrimination case, is it a proper summary judgment standard for a federal court to defer to the judgment of a hospital "peer review" committee when evidence of discrimination and comparative evidence relating to patient care of other anesthesiologists in the department was excluded from that "peer review" and the hearing resulted in the removal of all female Asian anesthesiologists?

As the motion for rehearing with suggestion for rehearing en banc (App. 57) indicates this case presents a case of conflict between the circuits as to the value that can be placed on an ad hoc hearing regarding deference to professional judgment. *Bolt v. Halifax Hospital Medical Center*, 891 F.2d 810 (11th Cir.), *cert. denied*, 495 U.S. 924 (1990), *Miller v. Indiana Hospital*, 843 F.2d 139 (3rd Cir. 1988), *cert. denied*, 488 U.S. 87 (1990), and *Brown v. Presbyterian Health Care Service*, 101 F.3d 1324 (10th Cir. 1996), *cert. denied*, 134 L.Ed. 2d 564 (1997).

Dr. Vakharia alleged that the hospital employed a private entity, the ASA, whom she later learned had earned a reputation as a convenient method of effectuating racial cleansing from the anesthesia staff of foreign medical graduates, as a willing tool in conducting a so-called "peer review" of Dr. Vakharia's anesthesia services. Although there was no comparability between the cases selected for review in which anesthesia services had been provided by Dr. Vakharia (or other "juniors") with the far simpler cases selected by the Hospital for review by the ASA for "senior" physicians, Dr. Vakharia's expert

witness eventually was able to examine both sets of patient charts and render an opinion that anesthesia errors were in fact more frequent and more serious with respect to the so-called "senior" anesthesiologists.

District Judge Milton I. Shadur stated on July 14, 1993 while ruling on a discovery motion in this case:

> "Chief Judge Moran talked about limiting the deposition to quality of care. But . . . quality of care is necessarily a comparative determination – no different in that sense from, for example, a case involving employment discrimination, when determining the nature of the conduct vis-a-vis the plaintiff may well necessitate inquiry into comparable conduct as to others, because that's part of the measure, as in this case, of the quality of care. So . . . it would be an unduly restrictive reading to suggest that a deposition as to the quality of Dr. Vakharia's medical care forecloses inquiry into other cases involving other doctors, as long as there's a demonstration, . . . of comparability."

However, the ad hoc hearing panel in the Hospital, comprised in several instances of physicians who had been operating surgeons (and for whose own quality of medical care was potentially at issue although none had reported their own cases as implicating anesthesia complications), refused to permit evidence of discrimination or evidence that the ASA reviewers had been presented with a "loaded game board" of cases selected on Dr. Vakharia by Dr. Loeber to purportedly illustrate anesthesia errors. In fact, the only instance in which Dr. Vakharia ever went to trial on an allegation of malpractice (one of the cases of an alleged punctured esophagus), the jury

took but nine minutes of deliberation to acquit Dr. Vakharia.

The district court applied the *Price Waterhouse v. Hopkins*, 490 U.S. 228 (1988) mixed-motive test stating, "Even if Dr. Loeber and others had been motivated by discrimination, the suspension would stand if the hearing committee and subsequent reviewers reasonably believed that plaintiff did not provide the quality of care the hospital required." When such a hearing committee precludes testimony of discriminatory animus and denies testimony on comparability, it may immunize itself and its decisions from attack by a screen of plausible denial.

Whether judicial deference is appropriate for a hearing process in which discrimination charges are ruled out of bounds, and in which comparative analysis of charts of other anesthesiologists was prohibited, is obviously a very important question for the medical system of this country. Indeed, such deference disserves the ordinary purposes of deference to professional judgment. As this court recognized in *Pinhas v. Summit Health, Ltd.*, 500 U.S. 322 (1991), and *Patrick v. Burget*, 486 U.S. 94 (1988) the consequences of anti-competitive conduct by physicians under the guise of allegations of improper care can be devastating to an impacted professional who may never be able to be employed again because of required reporting to state and federal agencies, and may directly disserve the interests of providing excellent, modestly priced, patient care.

The opinion by the Seventh Circuit gives no indication that it considered such issues, but deferred to the

results of the ad hoc hearing, an ad hoc hearing that Dr. Vakharia would describe more as a charade of a hearing than a real hearing. If such deference is appropriate, then all physicians who are told, "we will air your dirty laundry in public," would be well-advised to steal away in the night, as did the two other Asian anesthesiologists also accused of substandard anesthesia care by the ASA report, in the hope (realized in this case) that good letters of reference would be forthcoming from the Hospital for such voluntary flight, and that no required reporting would occur for such physicians (as did not occur in this case).

The next two questions presented are closely interrelated:

II. When a complaint alleges a conspiracy between a national association of anesthesiologists and the Hospital to eliminate foreign born medical graduates from Hospital staff through a phoney "peer review," but depositions are denied of individuals who drafted the ASA report which formed the pretextual basis for termination, and no ability was granted to demonstrate that the ASA had been involved in similar activity with respect to other area hospitals, are such denials appropriate?

III. Is denial of leave to amend the complaint appropriate when defamation counts are based upon belated false reporting of alleged improper medical care above and beyond the findings of a peer review committee to state and federal authorities years after the bringing of the instant lawsuit?

It is even more important to the vitality of the organization of the medical system of the United States, when a national association offers, as in this case, its services for a fee to "evaluate" medical staff of a hospital, and then becomes, as in the instant case, a convenient justification for the predilections and biases of the controlling authorities at a hospital, can such an institution avoid depositions to hide its actions.

In the instant case, all cases selected for review by the visiting ASA anesthesiologists were selected by a competing anesthesiologist, Dr. Loeber, who admitted to a nurse that she was looking for Dr. Vakharia's cases for "anesthesia wars." No unbiased random sample, or other systematic device was employed. The dates of Dr. Vakharia's cases alone demonstrate that different criteria were employed for selecting her cases, but other measures, (length of operation and the seriousness of health status of the patient) also indicate different selection criteria for Dr. Vakharia's cases. "Senior" cases were virtually all within the last year, mostly for patients who were in fairly good operative condition, and for relatively short operations. Indeed, indicated "senior" cases of complications, including an operating room death, were reported neither to the Quality Assurance Department of the Hospital, nor to the ASA reviewers. In contrast, however, cases selected by Dr. Loeber for review of "juniors" went back several years, and for Dr. Vakharia to 1980! Cases were not selected by examining reports to the Hospital Quality Assurance Committee (which had more "senior" cases complained about that cases involving the "juniors"). Yet despite the difference in the nature of cases – more complex and longer anesthesia cases for Dr.

Vakharia – her expert witness – who years after the ad hoc hearing was able to examine for the first time the more simple cases conducted by "senior" anesthesiologists, found more serious and more frequent anesthesiology errors in "senior" cases.

Discovery was barred, however, on such issues as to who actually wrote the ASA report, which was the basis for suspending all female Asian anesthesiologists at Dr. Vakharia's ad hoc hearing. Dr. Vakharia was barred from introducing evidence of an ASA report at another area hospital which not only illustrated similar attacks on foreign born medical graduates at a sister institution by ASA reviewers, but also demonstrated a striking lack of detail in the ASA report in the instant case. In effect, the ASA was permitted to cloak its conduct behind claims of patient confidentiality, and avoid ordinary discovery processes.

Another closely related question of some importance in a summary judgment case is the fourth issue:

> IV. Is it proper to refuse to consider the 12m statement of uncontested facts to which the defendants filed no response, and which the court ignored, including the affidavit of plaintiff's expert witness anesthesiologist to the effect that errors revealed on the face of medical charts by white "senior" anesthesiologists were substantially more serious than those errors "alleged" of "junior" female Asian anesthesiologists on the grounds that such an opinion should have been expressed in the Hospital ad hoc hearing, when the Hospital charts for

"senior" anesthesiologists were not available until years later through discovery, and the ad hoc hearing had barred testimony regarding discrimination, even though medical peer evaluation is intrinsically a comparative process?

The ASA refused in the instant case only to conduct a review of Dr. Vakharia's cases, maintaining to the Hospital that peer review was intrinsically comparative. Yet in the conduct of the review, the Hospital (through Dr. Loeber) was allowed to select the cases, and the ASA reviewers' attitude that "It's their hospital, they can do whatever they want," pervaded their review. Obviously a material issue of fact existed as to whether Dr. Vakharia met, or indeed, exceeded, the standard of anesthesia care ordinarily provided at Swedish Covenant Hospital.

Both courts below opined that such comparative evidence should have been introduced in the ad hoc hearing, although the patient charts upon which any such comparative analysis could be based, were unavailable until years later after discovery production in the instant case.

Lastly, the fifth issue:

V. Whether it is proper to apply a test such as that announced in *Alexander v. Rush North Shore Medical Center*, 101 F.3d 487 (7th Cir. 1996) to determine ability to raise Title VII and Age Discrimination in Employment claims when a Hospital by contract embodied in Hospital by-laws incorporates rights against discrimination, but the Hospital entirely controls through medical credentialling the ability of an anesthesiologist to

> practice her employment, and may destroy such ability to be employed by reporting to state and federal authorities alleged issues of medical competence?

presents an important issue regarding the scope of coverage of Title VII and the ADEA for all "independent contractors" such as anesthesiologists. Anesthesia practice is entirely dependent on being accredited to a hospital staff. The Seventh Circuit found that Dr. Vakharia should be denoted as an independent contractor, and thus claim no rights under Title VII or ADEA, despite the statutes themselves, and despite the fact that by-laws of the Hospital incorporated just such protections against discrimination. The remedial objectives of both Title VII and ADEA is thereby totally eviscerated with respect to the relationship between hospitals and anesthesiologists, despite anesthesiologists' symbiotic relationship with hospitals.

This court's decision in *Robinson v. Shell Oil Company*, 519 U.S. 337 (1996) clearly rejects the methodology employed by the Seventh Circuit in the *Alexander* decision and leaves *Alexander* as doubtful authority. In particular note 4 in *Robinson*, states in part: "Petitioner's examples of non-Title VII cases using the term 'employee' to refer to a former employee are largely irrelevant, except to the extent they tend to rebut a claim that the term 'employee' has some intrinsically plain meaning." Furthermore, in resolution of the ambiguity of the term "applicants" for § 704(a) this court stated that:

> "Because the term 'applicants' in § 704 is not synonymous with the phrase 'future employees,' there is no basis for engaging in the further (and questionable) negative inference that the inclusion of the term 'applicants' demonstrates intentional inclusion of former employees." This court further stated in *Robinson*, "Finding that the term 'employees' in § 704(a) is ambiguous, we are left to resolve that ambiguity. The broader context provided by other sections of the statute provides considerable assistance in this regard. As noted above, several sections of that statute plainly contemplate that former employees will make use of the remedial mechanisms of Title VII. . . . Indeed § 703 expressly included discriminatory discharge as one of the unlawful employment practices against which Title VII is directed. 42 U.S.C. § 2000e-2(a). Insofar as § 704(a) expressly protects employees from retaliation for filing a charge under Title VII, and a charge under § 703(a) alleging unlawful discharge would necessarily be brought by a former employee, it is far more consistent to include former employees within the scope of 'employees' protected by § 704(a)."

Rejection of this negative inference in *Robinson* refutes the similar inference that the word "employees" excludes independent contractors from protection under Title VII and ADEA. If Congress meant to exclude such entities, it could have said so. *See also Armbruster v. Quinn*, 711 F.2d 1332, 1346 (6th Cir. 1983) which saw no dichotomy between employees and "independent contractors" enshrined in Title VII and held that unless specifically excluded, the ambiguity should be resolved in

favor of coverage. (Citing *NLRB v. Hearst Publications*, 322 U.S. 111, at 129 (1944)).

This court in *Robinson* further stated:

> "In further support of this view, petitioner argues that the word 'employees' includes former employees because to hold otherwise would effectively vitiate much of the protection afforded by § 704(a). . . . According to the EEOC, exclusion of former employees from the protection of § 704(a) would undermine the effectiveness of Title VII by allowing the threat of post-employment retaliation to deter victims of discrimination from complaining to EEOC, and would provide a perverse incentive for employers to fire employees who might bring Title VII claims. Those arguments carry persuasive force given their coherence and their consistency with a primary purpose of anti-retaliation provisions, maintaining unfettered access to statutory remedial mechanisms."

Hearst rejected for NLRA purposes the use of such tests as the common law, or the local state law, to determine who an employee was. 322 U.S. 122-124. Instead a functional test was determined most appropriate that looked at the purpose for which the NLRA was enacted, i.e., national purposes to be administered by a national agency. 32 U.S. 123. "Both the terms and the purpose of the statute, as well as the legislative history, show that Congress had in mind no such patchwork plan for securing freedom of employee organizations and of collective bargaining." *Id.* Coverage should not depend upon the characterization of hospital-based physicians as independent contractors or employees under state law.

Compare *Advincula v. United Blood Services*, 176 Ill. 2d 1, 678 N.E. 2d 1009 (1996) (which frequently referred to medical professionals as employees or agents of hospitals). Title VII coverage should not depend upon the manner in which a particular state characterizes independent contractors versus employees, and/or pure independent contractors and independent contractors who are also agents. Such determinations would be fact intensive (as both *Nationwide Mut. Insurance v. Darden*, 503 U.S. 318 (1992) and *Knight v. United Farm Bureau Mut. Ins. Co.*, 950 F.2d 377 (7th Cir. 1991), multifactorial tests indicate), which would seriously burden the EEOC and frustrate the central purpose of Title VII, i.e., eliminating discrimination employing the full Commerce Clause power of Congress. U.S. Constitution, Art. I, § 8, cl. 3. Congressional purposes for enacting Title VII were far broader than those for enacting ERISA. ERISA primarily concerns securing retirement and benefits from a particular employer – hence Employee Retirement and Income *Security* Act. Narrow reading of that act does not justify narrow reading of Title VII and the Age Discrimination Statute, 29 U.S.C. § 623 *et seq*. Both the latter statutory schemes protect individuals from discriminatory conduct from employers, labor unions and employment agencies. Both potential and past employees are covered by both statutes, and an employment relationship with the potentially liable party is not required by either statute. In other words, status as an employee or an independent contractor is not a determinant for coverage under Title VII or § 623.

See, Daniels v. Pipefitters Ass'n Local Union No. 597, 945 F.2d 906, 915 (7th Cir. 1991); *King v. Chrysler Corp.*, 812

F.Supp. 151, 153 (E.D. Mo. 1993) ("the statute [Title VII] does not specify that the employer committing the unlawful employment practice must employ the injured individual."); *Graves v. Women's Professional Rodeo Ass'n*, 708 F.Supp. 233, 235 (W.D. Ark. 1989) (Once an employer is covered by the Act, Title VII extends to any aggrieved individual with regard to the existence of a traditional employment relationship).

Such coverage is within the plain meaning of 2000e-2(a)(1) and (2) which state in part:

> to fail or refuse to hire or to discharge any *individual, or otherwise to discriminate* against any *individual* with respect to his compensation, terms, conditions, or privileges of employment, because of such *individual's* race, color, religion, sex or national origin; or 2) to limit, segregate or classify his employees or applicants for employment in any way which would deprive or tend to deprive any *individual of employment opportunities or otherwise adversely affect his status as an employee*, because of such *individual's* race, color, religion, sex or national origin. (emphasis added)

Dr. Vakharia's serious problems commenced when she complained that she was being discriminated against, and "anesthesia wars" commenced at the hospital. Her ability to be employed by future patients was even more severely impacted by the hospital in the instant case, than was Mr. Daniels' employment prospects by the union hiring hall discrimination. *Daniels, supra.*

In short, this case presents important, serious questions about the structure of the medical peer review process and the proper relationship of judicial review to that process.

CONCLUSION

Wherefore, Petitioner, Usha Vakharia, M.D., respectfully requests this court to grant the writ of certiorari to review the decision of the United States Court of Appeals for the Seventh Circuit.

Respectfully submitted,

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Usha VAKHARIA, M.D., Plaintiff-Appellant,

v.

SWEDISH COVENANT HOSPITAL, Nancy Loeber, M.D., Demetrius A. Trakas, M.D., et al., Defendants-Appellees.

No. 97-4235.

United States Court of Appeals, Seventh Circuit.

Argued Feb. 17, 1999.

Decided Sept. 9, 1999.
Rehearing En Banc Denied Dec. 7, 1999.

CUDAHY, Circuit Judge.

Usha Vakharia worked as an anesthesiologist at Swedish Covenant Hospital (SCH) from 1974 until 1989 when her hospital privileges were terminated ostensibly because of a lack of quality in her care of her patients. Vakharia filed a seven-count complaint against SCH and other defendants alleging, among other things, discrimination on grounds of race, national origin, sex and age. The district court entered summary judgment in favor of the defendants on all counts. Vakharia now appeals and we affirm.

Background

Vakharia, a foreign-born, Asian-American woman and over the age of 40 at all relevant times, is a board-certified anesthesiologist, trained in the United States in her specialty. In 1974, she was appointed to the staff of SCH, a not-for-profit hospital located in Chicago. She was reappointed each year through 1989 and her privileges

were increased in 1981 and 1983. For several months in 1984, Vakharia served as the acting head of the anesthesiology section. That same year, in response to complaints by the Chicago Board of Health regarding substandard equipment and improper equipment care, SCH took steps to improve its anesthesiology services. It hired Dr. Nancy Loeber, a white, American-born woman, as director of anesthesiology with a mandate to enhance the quality of anesthesiology care. Vakharia contends that she applied for the position of director but that her candidature was not considered; SCH points to a lack of evidence in the record that she had in fact applied.

In any event, by January 1986, anesthesiology had been designated a separate department within SCH. As chair of the department, Loeber assumed responsibility for supervising anesthesiology personnel – including staffing decisions and case assignments – and for establishing quality control procedures. The composition of the anesthesiology department changed considerably over the next few years. In 1984, all five anesthesiologists at SCH were foreign-born (four female and one male). Between 1985 and 1987, Loeber expanded the department with four new recruits (three male and one female), each of whom was white and American-born.

Loeber's first brush with Vakharia took place in March 1987, when Loeber conducted a performance audit on Vakharia. The audit identified 13 cases – 11 in the previous year – in which Vakharia had experienced difficulty intubating patients or had failed to properly supervise unstable patients in the recovery room. Responding to Loeber's request for an explanation, Vakharia denied that the 13 cases reflected problems with her care and

claimed that Karen Filipkowski, the nurse who had prepared several of the incident reports, was biased against her. In September 1987, motivated by a desire to spend more time with her family, Vakharia requested and received permission from Loeber to go on part-time rotation. The following March, Loeber conducted a poll of 35 of the 71 hospital surgeons concerning their preferences among the anesthesiologists. Of the responses received, Vakharia was the least, or close to the least, preferred.

In January 1988, Loeber introduced new criteria for the assignment of cases among the anesthesiologists on the basis of senior and junior status. Originally, board-certification was to be the benchmark for senior status but Loeber subsequently decided to determine seniority based on her own assessment of medical competence. Three anesthesiologists were classified as senior: Johanna Chookaszian (a white, American-born female), Howard Konowitz (a white male) and Tun Myint (an Asian-born male). Of the three, only Chookaszian was board-certified On the other hand, in April 1988, Vakharia was classified as junior despite the fact that she was board-certified. Around the same time, two other female Asian-American anesthesiologists were also placed in junior status. Loeber wrote to each of the three indicating that she could not guarantee them work and suggesting that they explore employment opportunities elsewhere.

In June 1988, Vakharia requested that she be restored to full-time rotation and designated a senior anesthesiologist. Loeber refused, stating that the departmental caseload would not support another full-time position and that Vakharia had not demonstrated sufficient proficiency in dealing with complex cases. On the basis of a review

conducted by the Quality Assurance Department, Loeber identified 66 cases in which Vakharia had demonstrated inadequate job performance. Vakharia complained to SCH's Medical Executive Committee (MEC) which appointed a task force to look into the matter. The task force recommended that the MEC defer to Loeber's evaluation as chair but voted to retain an outside consultant to conduct an independent review. By this time, working relations between Loeber and Vakharia had reached an all-time low.[1]

In November 1988, the American Society of Anesthesiologists (ASA), an independent association of anesthesiologists, was brought in to review the anesthesiology department. The ASA reviewers, Drs. Ronald Wender and Louis Blancato, were asked to address three specific issues: (1) the staffing needs of the department, (2) the quality of care provided by certain individual anesthesiologists and (3) the possible restructuring of the department.[2] Wender and Blancato reviewed materials submitted by SCH and by Vakharia, conducted on-site visits to the hospital and interviewed individual anesthesiologists. One or both of them spoke with Vakharia on three occasions, and Wender personally observed Vakharia at work in the operating room. The resulting

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[1] For example, Vakharia began soliciting work primarily from foreign medical graduates. She also initiated her own review of the records of other anesthesiologists. Loeber responded by restricting Vakharia's access to Loeber's office where some emergency supplies were housed.

[2] The hospital played no role in the selection of Wender and Blancato. Moreover, neither reviewer had any prior association with Loeber or Vakharia.

ASA report, completed in June 1989, specifically criticized the quality of care provided by Vakharia and the two other female, Asian-American anesthesiologists. The report noted that all three anesthesiologists were responsible for "some very serious complications attributable to substandard care . . . indicative of a poor quality of anesthesia care, rather than a complication which one would expect as a natural result of anesthesia and/or surgery involved." Appellant's 2d Supp.App., tab 6 at 13. In Vakharia's case, the report identified general problems intubating patients and cited inadequate management of complex classes of cases. The ASA recommended that the staff privileges of Vakharia and the two other female, Asian-American anesthesiologists not be renewed.[3] SCH gave each of the three the option to resign. Only Vakharia chose to stay on and was duly suspended on July 31, 1989. In the meantime, Loeber had resigned on April 27, 1989, effective July 1, 1989.

On August 24, 1989, Vakharia requested a formal due process hearing under the SCH bylaws. An ad hoc peer review committee of five SCH physicians – appointed by the hospital administration – reviewed documentary evidence and conducted 19 days of hearings into the propriety of Vakharia's summary suspension. Attorneys were allowed to attend in an advisory capacity only, although Vakharia's attorney or, alternatively, one of her experts, was permitted to conduct cross-examination on her

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[3] The ASA noted that the ongoing dispute between Loeber and Vakharia had created a rift in the staff of SCH and that the foreign medical graduates saw Vakharia as a rallying point for preserving their presence at SCH.

behalf. Of SCH's four witnesses, two were key: Loeber testified for SCH on the problems she had identified with the quality of Vakharia's care, and Wender delivered his independent evaluation of Vakharia's performance gleaned through the ASA review process. For her part, Vakharia presented 21 witnesses in all. Seventeen SCH physicians testified that they had observed no improprieties on Vakharia's part and that they had confidence in her ability to care for their patients. Vakharia also brought in two experts: Dr. Floyd Heller, Associate Professor of Anesthesiology at Rush Medical College, and Dr. James O'Brien, Chief of Anesthesiology at Central DuPage Hospital. Heller and O'Brien generally defended the quality of Vakharia's care but were critical of some of her practices. Although Vakharia chose not to testify directly on her own behalf, she was questioned by SCH.

The committee found that "Dr. Vakharia's treatment of patients over a period of years did not meet the requisite standard of care and her professional judgment is so severely impaired that she is a potential threat to patients." Appellant's 2d Supp.App., tab 7 at 6. Thus, it was the unanimous recommendation of the committee that Vakharia's suspension be affirmed and that she not be reappointed to the medical staff. The committee relied in large measure on the ASA report and on the testimony of Wender whom it considered "extremely well-qualified, neutral and objective." *Id.* at 3. In contrast, the committee found Vakharia's own witnesses unpersuasive.[4] In short,

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[4] The testimony of Heller and O'Brien was described as "vague, overly broad and unconvincing." Appellant's 2d Supp.App., tab 7 at 4. And the contribution of the 17 physicians

the committee concluded that "none of Dr. Vakharia's witnesses effectively rebutted the compelling testimony of Dr. Wender and Dr. Loeber." *Id.*[5]

SCH adopted the committee's recommendation and terminated Vakharia's hospital privileges. Vakharia then unsuccessfully appealed the decision through two further levels of internal review: the appellate committee (a body appointed under the SCH bylaws) and the Board of Directors. Her termination was affirmed on September 13, 1990. Vakharia had initiated proceedings before the EEOC as early as August 4, 1989, which led in due course to the present lawsuit. Before the district court, she alleged (1) discrimination in violation of Title VII, the ADEA, and §§ 1981 and 1985, (2) breach of contract, (3) breach of SCH bylaws, and (4) a Sherman Act conspiracy claim. The defendants moved for summary judgment on all counts, and Vakharia brought her own motion for partial summary judgment (on all claims other than the Sherman Act claim). The district court concluded that Vakharia had failed to raise a genuine issue as to whether the termination of her hospital privileges was based on a

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was, in the committee's view, more in the nature of character than expert testimony.

[5] The committee expressed its disappointment at Vakharia's unwillingness to engage the review process in earnest; specifically, her failure to testify personally on her own behalf, answer directly the questions of committee members or address specific cases relating to the quality of her care. It noted that in her cross-examination, Vakharia "steadfastly avoided asking Dr. Wender questions about her several cases which he specifically examined," despite the fact that the committee "repeatedly implored [her]" to do so. Appellant's 2d Supp.App., tab 7 at 3.

good faith belief that the quality of her care was substandard. Determining that her various claims essentially turned on the same facts, the district court granted the defendants' motion for summary judgment and denied Vakharia's motion for partial summary judgment.

Standard of Review

We review the district court's decision to grant summary judgment de novo, *see Johnson v. Zema Systems Corp.*, 170 F.3d 734, 742 (7th Cir.1999), applying the same criteria as the district court. *See Rodriguez v. City of Chicago*, 156 F.3d 771, 775 (7th Cir.1998). We review the record and all reasonable inferences from it in the light most favorable to Vakharia, the non-movant. *See Senner v. Northcentral Technical College*, 113 F.3d 750, 754 (7th Cir.1997). To defeat summary judgment, she must set forth specific facts demonstrating that there is a genuine issue for trial. *See* Fed.R.Civ.P. 56(c); *Denisi v. Dominick's Finer Foods, Inc.*, 99 F.3d 860, 864 (7th Cir.1996).

Employment Relationship

The district court determined that Vakharia lacked standing to assert Title VII and ADEA claims because she was an independent contractor and not an employee. In *Alexander v. Rush North Shore Medical Center*, we held that an anesthesiologist with staff privileges at a hospital is an independent contractor on the basis of the following five-factor test:

> (1) the extent of the employer's control and supervision over the worker, including directions on scheduling and performance of work,

> (2) the kind of occupation and nature of skill required, including whether skills are obtained in the workplace, (3) responsibility for the costs of operation, such as equipment, supplies, fees, licenses, workplace, and maintenance of operations, (4) method and form of payment and benefits, and (5) length of job commitment and/or expectations.

101 F.3d 487, 492 (7th Cir.1996) (internal quotation and citation omitted). Among other things, we noted that Dr. Alexander possessed significant specialized skills and had authority to exercise his own independent discretion concerning the care he delivered to his patients; he was self-employed for tax purposes and was responsible for paying for his own malpractice insurance and employment benefits; and he billed his patients and collected fees from them directly. *See id.* at 493.

The present case is on all fours with Alexander. While Vakharia's situation was not identical with that of Alexander in all respects – for example, she could not associate herself with other hospitals – her responsibilities and working arrangements were essentially the same. It is undisputed that Vakharia was self-employed for tax purposes, that she paid her own malpractice insurance and that she received no benefits from SCH. That the anesthesiologists at SCH were regarded as independent contractors is confirmed by an agreement for anesthesiology department services concluded between Loeber and SCH. The agreement expressly refers to anesthesiologists as independent contractors, not employees.[6]

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[6] The agreement states: "Anesthesiologists to be Independent Contractors: In the performance of the work,

Vakharia claims that her situation is distinguishable from Alexander in the degree of control SCH exercised over her work. We have previously recognized that the employer's right to control is the most important though by no means the sole element in the equation. *See Ost v. West Suburban Travelers Limousine, Inc.*, 88 F.3d 435, 438 (7th Cir.1996). But Vakharia does not point to any specific evidence that would substantiate her claim that SCH exercised close control or call into question the express statement in the agreement between Loeber and SCH to the contrary.

As a separate matter, Vakharia asserts that she is an employee for the purposes of her discrimination claims by virtue of her 1984 application for director of the anesthesiology service (the position to which Loeber was appointed). We disagree. The same agreement between Loeber and SCH confirms that Loeber – the occupant of the position at all relevant times – was an independent contractor as well. And, as in the case of the anesthesiologists Loeber supervised, there is nothing in the record that would cause us to doubt that Loeber's relationship with SCH mirrored the agreement in practice. Thus, whether as an anesthesiologist or an applicant for the

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duties and obligations undertaken by Dr. LOEBER under this Agreement, it is understood and agreed that Dr. LOEBER and those physicians specializing in Anesthesiology contracting with her to render the services called for in this Agreement, are at all times acting and performing as an [sic] independent contractors. The HOSPITAL shall neither have nor exercise control or discretion over the methods by which Dr. LOEBER or her physician contractors shall perform their work . . . ". Appellant's Supp.App., tab 10 at 5.

position of director of the service, Vakharia was an independent contractor at all relevant times. Since Vakharia was not an employee, we agree with the district court that her Title VII and ADEA claims must fail.

Sections 1981 and 1985

We turn to Vakharia's remaining discrimination claims, Count II (§ 1981 claims against SCH and Loeber) and Count V (§ 1981 and § 1985 claims against SCH, Loeber, Chookaszian, and certain individual members of the SCH Board of Directors). Section 1981 prohibits discrimination on grounds of race in the making and enforcing of contracts. *See* 42 U.S.C. § 1981(a). Section 1985 bars conspiracies that interfere with civil rights, on any grounds. *See* 42 U.S.C. § 1985(3). In examining Vakharia's § 1981 claim, we employ the same framework that we use with respect to Title VII claims. *See Gonzalez v. Ingersoll Milling Machine Co.*, 133 F.3d 1025, 1035 (7th Cir.1998); *Bratton v. Roadway Package System, Inc.*, 77 F.3d 168, 176 (7th Cir.1996).

A claim of employment discrimination can be proved by showing direct or indirect evidence of discrimination. Where, as here, the plaintiff is relying on indirect evidence,[7] we apply the familiar burden-shifting method

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[7] Vakharia purports to present evidence of direct discrimination in the form of certain isolated comments, e.g., on the part of Loeber (that Chookaszian was "an all-American blond with a funny last name") and SCH President, James McCormick (that Vakharia should resign in order to avoid airing "dirty laundry"). Direct evidence of discrimination, however, is "evidence which if believed by the trier of fact, will

established by *McDonnell Douglas Corp. v. Green*, 411 U.S. 792, 93 S.Ct. 1817, 36 L.Ed.2d 668 (1973), and its progeny. To establish a prima facie case of employment discrimination, Vakharia must present evidence that: (1) she was a member of a protected class; (2) she was qualified for the job in question or was meeting SCH's legitimate performance expectations; (3) she suffered an adverse employment action; and, (4) SCH treated similarly situated persons outside the protected class more favorably. *See Johnson*, 170 F.3d at 742-43; *Gonzalez*, 133 F.3d at 1032.

Once Vakharia establishes this prima facie case, there is a presumption of discrimination that obliges SCH to produce a legitimate, nondiscriminatory reason for its decision. If SCH can so do, the burden shifts back to Vakharia to present evidence that SCH's proffered reason is pretextual. *See Debs v. Northeastern Illinois Univ.*, 153 F.3d 390, 395 (7th Cir.1998); *Gonzalez*, 133 F.3d at 1032. Pretext in this context means "a lie, specifically a phony reason for some action." *Jackson v. E.J. Brach Corp.*, 176 F.3d 971, 983 (7th Cir.1999) (internal quotation and citation omitted). Vakharia may establish pretext by showing evidence that SCH was more likely than not motivated by

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prove the particular fact in question without reliance upon inference or presumption." *Greenslade v. Chicago Sun-Times, Inc.*, 112 F.3d 853, 863 (7th Cir.1997) (internal quotation and citation omitted). In the present case, we endorse the district court's conclusion that these comments – which are in the nature of stray remarks – though insensitive, do not in themselves establish a discriminatory animus. *See Fuka v. Thomson Consumer Electronics*, 82 F.3d 1397, 1403 (7th Cir.1996) (noting that in order to establish direct evidence of discrimination, a plaintiff must identify a link between stray workplace remarks and the adverse employment action at issue).

a discriminatory reason or that SCH's explanation is not worthy of credence (i.e., that the explanation was factually baseless, that it was not SCH's actual motivation or that it was an insufficient rationale for SCH's action). *See id.* at 983; *Debs*, 153 F.3d at 395-96. Vakharia bears the ultimate burden of demonstrating an impermissible motive or intent. *See St. Mary's Honor Center v. Hicks*, 509 U.S. 502, 506-07, 113 S.Ct. 2742, 125 L.Ed.2d 407 (1993); *Johnson*, 170 F.3d at 742.

At least at first blush, Vakharia appears to have the makings of a prima facie case: she and two other Asian-American anesthesiologists had their privileges terminated whereas their white, American-born colleagues – some of them new recruits – remained in place. It is undisputed that Vakharia comes within the protected class and that she has suffered an adverse employment action – the termination of her staff privileges. Thus, SCH concedes that she has met the first and third factors of her prima facie case. The key issue on appeal is whether Vakharia was meeting SCH's legitimate performance expectations (the second element of her prima facie case). Of course, this element of the prima facie case dovetails with the issue of pretext; both inquiries focus on the factual question of whether Vakharia was providing an adequate standard of patient care. Since the parties have chosen to frame the case in terms of pretext, we will follow their lead and, for present purposes, we will assume that Vakharia has made out a prima facie case. *See Debs*, 153 F.3d at 395-96; *Fuka v. Thomson Consumer Electronics*, 82 F.3d 1397, 1404 (7th Cir.1996). Thus, Vakharia has the burden of demonstrating that SCH's proffered nondiscriminatory reason for its action – that her care

was substandard and harmful to her patients – was a mere pretext for discrimination. In so doing, Vakharia is constrained by the two-year statute of limitations for § 1981 claims: she must present evidence pertaining to events that took place after November 8, 1988 (two years prior to the filing of the present action).[8]

Vakharia maintains that Loeber undermined Vakharia's professional standing at SCH as part of a broader campaign to purge the anesthesiology department of foreign-born or foreign-educated personnel. An examination of staffing changes in the department lends some support to this view. Over a five-year period, the racial and/or ethnic makeup of the anesthesiology department underwent a significant transformation. In 1983, the professional staff was entirely foreign-born. Between 1985 and 1987, however, Loeber hired four white, American-born anesthesiologists. And, of course, in 1988, Vakharia and the two other female, Asian-American anesthesiologists were forced out of the department.

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[8] Vakharia's claim that SCH discriminated against her by refusing to consider her for the position of director of the anesthesiology section in 1984 falls outside the statute of limitations. Nor has Vakharia presented evidence of a continuing violation that would enable her to reach back to this time frame. Specifically, this claim is insufficiently proximate in time to Vakharia's other claims which, moreover, implicate other decisionmakers and involve other kinds of employment decisions. *See Filipovic v. K & R Express Systems, Inc.*, 176 F.3d 390, 396 (7th Cir.1999) (discussing the continuing violation doctrine in the more familiar context of workplace harassment). Thus, we need not consider whether Vakharia actually applied for the position in question – a factual contention which the appellees keenly dispute.

We are mindful that the value of this kind of circumstantial evidence is limited where, as here, the workplace is unusually diverse. At the time of the ASA review, for example, foreign-born or educated professionals comprised roughly half of SCH's medical staff and were equally represented on the MEC and in departmental chairs. Nevertheless, these changes in the composition of anesthesiology personnel clearly place a cloud of suspicion over Loeber's modus operandi.[9]

Such evidence standing alone, however, is insufficient to establish pretext. *See Testerman v. EDS Technical Prods. Corp.*, 98 F.3d 297, 304-05 (7th Cir.1996) (fact that terminated employees fell within the protected class, without more, did not cast doubt on employer's articulated reason for discharging one of them). The appellees contend that Loeber's staffing decisions were based purely on merit; after all, Loeber was appointed with a mandate to shake up and improve the department. To survive summary judgment, Vakharia must refute the appellees' contention that quality of care concerns motivated the termination of her privileges. We need not pass

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[9] Vakharia also attributes a discriminatory motive to Loeber's assignment of cases under the senior-junior classification. Although outside the statute of limitations, the events surrounding this practice may potentially lend support to claims coming within the statutory period. We note that the fact that Vakharia had voluntarily moved to part-time rotation may have had some bearing on the assignment of cases to others within the department. But in any event, since Loeber's primary rationale for denying Vakharia senior status was a lack of proficiency in her management of complex cases, the issue of case assignment falls within the broader question of quality of care which we address below.

judgment on whether Vakharia's care was or was not inferior by reference to standards within the hospital or the profession. The issue here is whether the ad hoc peer review committee – the primary decisionmaker in this case – genuinely believed that the care she provided was inferior. *See Debs*, 153 F.3d at 396; *Hartley v. Wisconsin Bell, Inc.*, 124 F.3d 887, 890 (7th Cir.1997) (plaintiff will not prevail if employer honestly believed in the non-discriminatory reasons it offered).

Vakharia maintains that the criticisms of the quality of her care were entirely without foundation. In support she relies principally on an affidavit by Heller, dated January 25, 1995, in which he expands on the testimony he delivered to the ad hoc peer review committee. *See* Appellant's Supp.App. at tab 8. Heller takes issue with Loeber on a number of counts. He states that many of her occurrence reports involving Vakharia's cases were undated or unsigned and that in some cases criticisms had not been made contemporaneously with the events outlined. He questions the accuracy of her testimony before the committee, identifying inconsistencies with respect to specific cases. Heller also challenges the scope of the ASA review of Vakharia's performance and the specificity of the report's findings. Unfortunately for Vakharia, however, the committee did not have the benefit of this evidence (Heller's expanded testimony) during its lengthy consideration of her case in 1988. Since our task is to focus on the honesty of the committee's explanation for its recommendation that Vakharia's privileges not be renewed, *see Debs*, 153 F.3d at 396, our inquiry is necessarily limited to the evidence that the committee actually had at its disposal.

On the basis of our review of the committee hearings, we think that the quality of care issue is a somewhat closer call than the district court would suggest. The record is by no means devoid of evidence favorable to Vakharia. Independent experts Heller and O'Brien testified that, in their view, Vakharia generally met the requisite standard of care. In addition, 17 SCH doctors testified that they had confidence in Vakharia's abilities. Notwithstanding the nonspecific nature of this evidence, we think that the committee may have been unduly dismissive of the contribution of these professionals to an evaluation of Vakharia's work performance.

Nonetheless, we subscribe to the district court's ultimate conclusion that significant aspects of Loeber's and Wender's testimony went unchallenged. The record indicates that Vakharia squandered ample opportunities to bolster her case before the committee. A reading of the transcript of the hearings suggests that neither she nor her experts got to grips with the heart of SCH's evidence, namely, the numerous specific cases involving allegedly improper care documented by Loeber and reviewed by Wender. Although Heller and O'Brien addressed certain of the cases cited by Loeber, their direct testimony was for the most part pitched at a general level of discussion. Heller – arguably Vakharia's most important witness – was asked by the committee to return for cross-examination on the quality of care issue but did not do so. Vakharia cross-examined Loeber and Wender at length but failed to challenge their testimony relating to specific

cases, notwithstanding the committee's express prompting in that direction.[10] Vakharia declined to exercise her right to testify on her own behalf. However, she did enter a tape recorded statement into the record. In the statement she challenged the propriety of the peer review process and leveled accusations at various members of the SCH administration. Her main defense to the ASA report – and its tacit endorsement of Loeber's specific allegations – was twofold: that the ASA experts saw only what SCH wanted them to see and that she herself was denied access to the relevant medical records. However, neither contention finds any support in the record. Under cross-examination by SCH, Vakharia was argumentative, at times refusing to respond to specific questions and instead resorting to attacks on Loeber's character and to criticisms of the committee.

We think it significant that in deciding to terminate Vakharia's privileges, the committee placed great store in the ASA report and the testimony of ASA expert Wender. The report was based on a thorough review by independent, qualified professionals on whose credentials the

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[10] During her first cross-examination of Wender, Vakharia made some attempt to question Wender's findings regarding specific cases. However, at that time, Wender appeared ill-equipped to engage in such a detailed discussion. In contrast, when Wender returned on a subsequent date for further, lengthy cross-examination, Vakharia failed to pose any questions about specific cases. The record shows that, at several junctures, committee members intervened and suggested that Vakharia direct her cross-examination to specific cases. Heller also conducted a limited cross- examination of Wender in which Wender gave relatively detailed answers to the few questions that related to specific cases.

committee was entitled to rely. Moreover, it specifically addressed the key issue of the quality of Vakharia's care. We can find no support in the record for Vakharia's claim that Wender and Blancato were not privy to all of the relevant information. Indeed, Vakharia has not raised any evidence to show that the ASA report was in any way tainted.

We have previously recognized that we "[do] not sit as a super-personnel department that reexamines an entity's business decisions." *Dale v. Chicago Tribune Co.*, 797 F.2d 458, 464 (7th Cir.1986). Vakharia cannot prevail if SCH "honestly believed in the nondiscriminatory reason [ ] it offered, even if the reason[ ] [is] foolish or trivial or even baseless." *Hartley*, 124 F.3d at 890; *Wolf v. Buss (America), Inc.*, 77 F.3d 914, 919 (7th Cir.1996). The bottom line: Vakharia has failed to show that SCH's explanation for the suspension of her privileges – that the quality of her care was substandard – was less than honest. Specifically, she has failed to raise a genuine issue that the committee was not acting in good faith reliance on the ASA report.[11] Vakharia calls into question the objectivity

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[11] Because Vakharia's claims accrued before the enactment of the Civil Rights Act of 1991, *see* 42 U.S.C. § 2000e-2(m), the district court also considered the case under the mixed motives standard articulated in *Price Waterhouse v. Hopkins*, 490 U.S. 228, 242, 109 S.Ct. 1775, 104 L.Ed.2d 268 (1989). While we need not address this issue, we note that the mixed motives inquiry is essentially the flip side of the pretext coin. Under *Price Waterhouse*, even if some or all of the appellees had been motivated by discrimination, they would not be liable if they could prove that the termination of Vakharia's privileges was based on a reasonable belief in the inadequacy of the quality of her care.

of the committee, but she fails to point to any direct evidence of bias. There is no doubt that the peer review process was mired in contention; the record is replete with exchanges (often heated) between Vakharia, her attorneys and her husband, on the one hand, and members of the committee, on the other, mainly in the context of disputes over procedural matters. But we can see nothing in the record that would suggest that Vakharia was denied the procedural safeguards generally associated with an internal review process. On the contrary, the 19 days of hearings – running to 3130 pages of transcript – suggest that the committee conducted an unmistakably lengthy and comprehensive inquiry.

In conclusion, we affirm the district court's decision to enter summary judgment in favor of the defendants and against Vakharia on her § 1981 claims. And since Vakharia cannot survive summary judgment on her § 1981 claims, her § 1985 claim also fails. *See Stevens v. Tillman*, 855 F.2d 394, 403-04 (7th Cir.1988) (noting that the statute does not create any substantive rights and that a "plaintiff must locate a right independently secured by state or federal law").[12]

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[12] The district court also granted summary judgment in favor of SCH on the Count IV state law claim of violation of provisions of the SCH bylaws. Recognizing that "Illinois law, both statutes and cases, reflects a significant hesitation about intruding into the peer review process," the district court held that there was no proof of a substantial violation or any actual unfairness in the peer review process. Mem. & Ord. Nov. 18, 1997, Appellant's Br. at A21. The court also rejected Vakharia's other allegations of bylaw violations – notably in relation to Loeber's practices regarding designation of status and assignment of cases – citing, first, a reluctance on the part of the

Sherman Act

Vakharia also appeals the district court's grant of summary judgment in favor of the appellees on the Count VI antitrust claim. Section 1 of the Sherman Act prohibits concerted anticompetitive activities – including conspiracies – designed to unreasonably restrain trade. *See* 15 U.S.C. § 1. The essence of Vakharia's claim is that SCH and the ASA (and various individuals associated with these entities) engaged in a conspiracy to purge anesthesiology departments of foreign medical graduates. Vakharia contends that the ASA's independent on-site review process provided a convenient mechanism whereby hospitals such as SCH could remove foreign medical graduates on performance-related grounds.[13]

The fate of this issue is foreshadowed by our discussion of Vakharia's employment discrimination claims: just as the inadequacy of the quality of her care justified the

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courts to review these types of practices and, second, Vakharia's failure to prove the allegations of discrimination that lie at the heart of her suit. Vakharia's appeal and reply briefs touch upon this issue in passing although the extent of her claim on appeal is by no means clear. She appears to focus her objections on the district court's rejection of her "right to be free from discrimination under the bylaws." Appellant's Br. at 40. We believe that the district court handled the issue appropriately, and we endorse its conclusion that the claim of discrimination in violation of the bylaws goes hand-in-hand with her federal discrimination claim.

[13] Vakharia argues that she was denied valid requests to conduct additional discovery with respect to her Sherman Act claim. However, bearing in mind the voluminous discovery which took place in this case, we believe that the district court acted within its discretion in this regard.

termination of her hospital privileges, so it provides a defense to the claim of an antitrust conspiracy. We have noted the absence of evidence that would challenge the ad hoc peer review committee's purported good faith reliance on the ASA report. Vakharia has not produced any evidence demonstrating that the ASA review process was tainted or, specifically, that the ASA conspired with individuals at SCH to weed foreign graduates out of the anesthesiology department. In other words, Vakharia has failed to show that SCH and ASA were engaged in unlawful concerted activity. *See Serfecz v. Jewel Food Stores*, 67 F.3d 591, 599 (7th Cir.1995). Thus, we endorse the district court's determination that the appellees are entitled to summary judgment on Count VI.[14]

AFFIRMED.

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[14] Vakharia also appeals the district court's denial of leave to file a fourth amended complaint to add state law claims for defamation, false reporting and commercial disparagement. The request came three years after the initial complaint was filed and at the stage when substantial discovery had been completed. In the circumstances, the district court did not abuse its discretion in denying Vakharia's motion on grounds of undue delay and substantial prejudice to the defendants. *See Speer v. Rand McNally & Co.*, 123 F.3d 658, 665 (7th Cir.1997); *Sanders v. Venture Stores, Inc.*, 56 F.3d 771, 774-75 (7th Cir.1995).

Usha VAKHARIA, M.D., Plaintiff,

v.

SWEDISH COVENANT HOSPITAL, et al., Defendants.

No. 90 C 6548.

United States District Court,
N.D. Illinois,
Eastern Division.

Nov. 18, 1997.

MEMORANDUM AND ORDER

MORAN, Senior District Judge.

In this pleading and discovery war plaintiff first filed a complaint of four counts. It ultimately expanded to a 50-page complaint with seven counts. The various claims were then the subject of several motions and opinions. We believe the pending claims resulting from that skirmishing are as follows:

Count I, a Title VII claim against Swedish Covenant Hospital (SCH).

Count II, § 1981 claims against SCH and Dr. Loeber relating to the formation of contracts with patients.

Count III, ADEA claims against SCH.

Count IV, breach of contract through violation of the Medical Staff Bylaws, a claim against SCH.

Count V, § 1981 and § 1985 claims against SCH, Dr. Loeber, Dr. Chookaszian, and certain named Board members.

Count VI, a Sherman Act, § 1 claim against SCH, the American Society of Anesthesiologists (ASA), Dr. Vacanti, Dr. Blancato, Dr. Wender, Dr. Loeber, Dr. Chookaszian, Dr. Myint and Dr. Konowitz.

Count VII, Title VII claims against SCH, Loeber and certain Medical Executive Committee (MEC) members.

Defendants SCH and Dr. Loeber moved on January 8, 1993, for summary judgment on Counts I-IV, and a long period of discovery intervened thereafter, until the last brief was filed on December 10, 1996. The SCH defendants thereafter, on January 30, 1997, filed a supplemental motion for summary judgment addressed to Counts V and VII, based on the same arguments, and plaintiff filed her own motion for partial summary judgment on May 21, 1997.

The briefing and the accompanying exhibits in this case are massive. The memoranda alone exceed well over 200 pages. The chronology of the motions is itself somewhat curious. In 1993 defendants filed a 46-page 12(m) statement. On February 10, 1995, plaintiff filed an 89-page 12(n) response but did not propose any uncontested facts herself. Some of the responses were cited to specific portions of the record. Most, however, depended on an all-inclusive affidavit by plaintiff at the end of the 12(n) statement. Then, on July 26, 1996, defendant filed a 40-page supplemental 12(m) statement that was a virtual rerun of the earlier statement, but it added an affidavit from Dr. Ronald Wender to reflect the fact that quality-of-care issues had been addressed after the earlier submission. Plaintiff responded again at the time of her "Response to Reply" of the defendants, the fourth brief

filed. This time, however, on December 10, 1996, she again filed a 12(m) response and added 566 paragraphs of additional facts, extending over some 106 pages. Many of those paragraphs of additional facts rely upon plaintiff's verification, although some are obviously hearsay and others are subjective conclusions. We will, however, make use of them to the extent we can.

Since this motion was first filed there have been two significant decisions by the Seventh Circuit. In *E.E.O.C. v. AIC Security Investigations, Ltd.*, 55 F.3d 1276 (7th Cir.1995), the court held that individuals who do not independently meet the Title VII and ADEA definition of "employer" cannot be held liable under those statutes. Accord, *Williams v. Banning*, 72 F.3d 552 (7th Cir.1995). In *Alexander v. Rush North Shore Medical Center*, 101 F.3d 487 (7th Cir.1996), the court held that, on the facts in that case, a self-employed physician with staff privileges at a hospital may not bring a Title VII action – or an ADEA action because the definition of "employer" is the same under both statutes – against the hospital, because the physician does not have an employment relationship with the hospital.

Plaintiff seeks to distinguish *Alexander*, arguing that its authority is questionable in light of two Supreme Court opinions and that the facts here are different. We note initially that any argument that the decision in *Alexander* is erroneous must be addressed to the Court of Appeals, not this court. Further, we are not persuaded by plaintiff's catalog of distinctions between her situation and that of the physician in *Alexander*, partly because of the facts stated by her in her 12(m) statement of December 10, 1996. Her exhibits include exhibit 18, the series of

contractual arrangements between the hospital and the chair of the anesthesiology department, Dr. Loeber. Those agreements expressly provide that the physicians in the department are independent contractors, who independently bill for their services and provide those services according to their professional judgment. Plaintiff's tax status was as an independent provider. Dr. Loeber had the authority to hire anesthesiologists, although the suspension of their staff privileges was subject to the due process procedures of the hospital. She also had the authority to assign the cases – an authority plaintiff claims was discriminatorily exercised. According to plaintiff, SCH signed an exclusive contract with a corporation, effective February 1, 1990, for the provision of anesthesiology services. This was after her suspension but before the ad hoc committee report and the termination of her staff privileges. On the basis of Alexander we are compelled to conclude that plaintiff was not in an employment relationship with SCH as a matter of law.

Plaintiff points to *Shrock v. Altru Nurses Registry*, 810 F.2d 658 (7th Cir.1987), and contends that SCH, as an employer, may be liable for conduct that interferes with employment with others. If that concept has vitality it can only relate to her difficulties in obtaining other positions after her staff privileges were terminated, not to her claims of discrimination in the assignment of cases and the like while she was practicing anesthesiology at SCH (and she would have difficulty in attributing discriminatory assignments to the hospital in any event, since the decisionmaker there was Dr. Loeber, an independent contractor who had that authority by virtue of her contractual arrangements). The § 1981 and § 1985 issues,

however, require a review of some discrimination claims in any event.

The most serious claim in this case ~~is~~ that plaintiff was discriminated against because of her national origin, color, race, sex and age in the termination of her staff privileges, as that ended her position at SCH, where she had practiced exclusively for many years, and led to public reporting to the Illinois Department of Registration and Education. Accordingly, we deal with that first. And we do so by first discussing what this case is not about. This case is not about a reduction in force, with plaintiff claiming that she was terminated discriminatorily while other less well-qualified persons were kept on. The SCH defendants claim that plaintiff did not meet minimum standards for SCH, that she was not qualified for the position. An employer need not compare an employee (we use employer-employee terminology as a matter of convenience) to other employees if the employer honestly, even if erroneously, concludes that the employee is not qualified for the position. A failure to review the qualifications of others may provide an argument that the judgment that plaintiff was not qualified was a pretext and not honestly made, but, ultimately, that plaintiff must prove the termination resulted from discrimination against her (and if she can show that the reasoning given was a pretext, a trier of fact can infer that the real reason was discriminatory). *Anderson v. Baxter Healthcare Corp.*, 13 F.3d 1120 (7th Cir.1994). We realize that we are using the entire McDonnell-Douglas standard here, even though the issue relates to the first step only, a showing of qualification, but we think analysis in pretext terms is useful here.

Plaintiff claims that her bad experiences began when Dr. Loeber came in as chairman in April 1995, although, according to her, others had been mistreated even earlier. She claims that her hours were cut because of Dr. Loeber's discriminatory conduct. The quality-of-care issues that resulted in the termination of staff privileges did not surface in a major way, however, until Dr. Loeber raised questions about thirteen of plaintiff's cases in a letter on March 17, 1987. The issue escalated and, ultimately, the MEC asked the American Society of Anesthesiologists (ASA) to review three issues: a surplus of physician anesthesiologists, quality of care by specific anesthesiologists (which included the plaintiff), and independent practice/organizational structure. An ASA committee, consisting of Dr. Ronald Wender and Dr. Louis Blancato, undertook a visitation and thereafter issued a report which, among other things, specifically criticized plaintiff's abilities and recommended that her staff privileges not be renewed. That led to plaintiff's summary suspension and a determination by the MEC that plaintiff's staff privileges not be renewed. The next step was the formation of an ad hoc hearing committee (hearing committee). That committee conducted nineteen days of hearings and arguments, compiled a record of 3130 pages, and received thirty-eight exhibits from SCH and over 200 from plaintiff. It unanimously recommended that the suspension and non-reappointment be affirmed. Those recommendations were adopted by the MEC on May 9, 1990. Plaintiff sought review by the SCH Board of Directors. The Board appointed an appellate review committee of six Board members. At the conclusion of the review process the committee

determined, in a 21-page report, that the recommendations should be adopted by the Board. The Board did so.

The primary decisionmaker in this process was the hearing committee, although the MEC, the appellate review committee and the Board all played significant roles in the ultimate decision. We think, then, it is useful to describe what the hearing committee heard and what it decided.

The summary of events just described is but a speck in the universe of facts submitted by the parties. We will, in due course, return in more detail to the events that led up to the hearing, keeping in mind that we have no wish to be drowned in a sea of irrelevant minutiae. We think, though, that it is helpful to consider the "climate" at the hospital at the time the hearing commenced.

Plaintiff had earlier complained of bias by a nurse, Karen Filipowski, who prepared several of the incident reports that led to inclusion of cases among the thirteen cases questioned in the March 17, 1987 letter. Represented by counsel, plaintiff complained of discriminatory treatment respecting the contemplated review, although it is not clear that she contended in June and July 1988 that it was based on age, race, gender or national origin. Still, it is clear that plaintiff thought, well prior to the ASA review, that Dr. Loeber was treating her unfairly. Then came the ASA review and its report on June 30, 1989, in which the polarization of the medical staff due to the conflict between Dr. Loeber and plaintiff is noted:

> To the Medical Staff this issue of "Dr. Vakharia vs. Dr. Loeber" has taken on a staff-wide interest. According to all parties, the problem has

> affected and divided the entire Medical Staff. To many staff members, especially the foreign medical graduates, it represents the Administration trying to undermine a physician because she is a foreign medical graduate. Many primary care physicians and surgeons who are foreign medicalgraduates apparently have been specifically requesting the service of Dr. Vakharia and using her as a rallying point for the preservation of the foreign medical graduate within the Medical Center. While this perception may or may not be a real issue within the institution, it nonetheless exists. The feelings of most staff members were very strong on this issue.

Then came the ASA Report, in which it was recommended that the staff privileges of the three Asian female anesthesiologists not be renewed. Two of them left the hospital. Plaintiff chose to fight the recommendation and she also filed discrimination charges on August 4, 1989. In the meantime, Dr. Loeber had resigned on April 27, 1989, effective July 1, 1989, citing her desire to leave the "political arena." Plaintiff was summarily suspended, she contends effective as of the date of the ASA Report, although the hospital insists that formal suspension came later. In any event, the suspension triggered a right to a due process hearing. A period of intense skirmishing between counsel for plaintiff and for the hospital (and, later, for the hearing committee) followed, including a state court lawsuit by plaintiff to get the hearing commenced.

By the time the hearing began the "climate" was obviously supercharged. Dr. Vakharia wished to compare her care with other anesthesiologists at the hospital. She

was committed to the view that there was absolutely no basis for criticizing the quality of her care and considered any criticism to arise from discriminatory motivations. Even during the review process those feelings were evident. The ASA Report notes:

> Dr. Vakharia is very emotional about this problem and considers it a personal attack on her integrity and ability. During numerous discussions, she viewed the consultants as "saviours" who had come to "clear" her name. There was no doubt that Dr. Loeber wished Dr. Vakharia, Dr. Puthumana and Dr. Chang to leave the institution and to replace them with anesthesiologists she felt would provide more sophisticated care.

The hearing committee insisted that the issue was whether or not plaintiff provided substandard care (and it is clear that the standard was somewhat higher than the standard for the larger community, and rather unclear how much higher that might be).

That mind set, the court believes, has had a significant and adverse impact upon both the hearing and this lawsuit. Plaintiff has painted with a very broad brush, at one time naming upwards of forty parties as discriminating against her. It is an approach she has carried over into other disputes. *See Vakharia v. Little Co. Of Mary Hospital*, 917 F.Supp. 1282, 1288 (N.D.Ill.1996). What the hearing committee was interested in, however, was the quality-of-care issue as it related to plaintiff. Even if Dr. Loeber and others had been motivated by discrimination, the suspension would stand if the hearing committee and subsequent reviewers reasonably believed that plaintiff did not

provide the quality of care the hospital required. *See Price Waterhouse v. Hopkins*, 490 U.S. 228, 242, 109 S.Ct. 1775, 1786, 104 L.Ed.2d 268 (1989).[1]

We have read the entire transcript of the hearing, which, as we said, extends to nineteen days and 3130 pages. One is struck by the paucity of plaintiff's response to the quality-of-care issue. While she complains that she was not permitted to have an attorney handle the questioning, she was allowed to have an attorney and one of her experts, Dr. Heller, cross-examine Dr. Wender. Moreover, the affidavit and deposition of Dr. Heller (we have read both in their entirety), submitted as part of this

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[1] Under *Price Waterhouse*, even if the employer in a Title VII does take race into account, the plaintiff will still not prevail if the employer can "prove that, even if it had not taken [an impermissible characteristic] into account, it would have come to the same decision regarding a particular person." *Id.* at 242, 109 S.Ct. at 1786. Plaintiff's case here is similarly a "mixed-motives" case. We recognize that *Price Waterhouse* has been abrogated by the Civil Rights Act of 1991(CRA), 42 U.S.C. § 2000e-2(m). However, the Supreme Court in *Landgraf v. USI Film Prod.*, 511 U.S. 244, 114 S.Ct. 1483, 128 L.Ed.2d 229 (1994) held that certain provisions of the CRA do not apply retroactively. Although the Supreme Court did not specifically address § 2000e-2(m), the Third and Ninth Circuits have held that the CRA does not apply retroactively as it relates to *Price Waterhouse*. *See Chenault v. U.S. Postal Serv.*, 37 F.3d 535, 538 (9th Cir.1994); *Hook v. Ernst & Young*, 28 F.3d 366, 370-73 (3d Cir.1994); *see also Cooke v. Illinois Central Railroad Co.*, No. 94 C 4415, 1996 WL 84230 n. 4 (N.D.Ill. Feb.26 1996). Because plaintiff's claims here accrued before the CRA was enacted her case is controlled by *Price Waterhouse*.

motion, reflect that plaintiff was fully capable of articulating what she perceived to be the weaknesses in Dr. Loeber's and Dr. Wender's critiques. Most of the cross-examination, however, was devoted, at length, to other matters.

When plaintiff cross-examined Dr. Loeber and Dr. Wender she was, on several occasions, asked by the committee to get to the cases. She did not. Dr. Wender returned for another session, to be devoted to discussion of the cases. He was not asked about them. Dr. Heller and another expert for plaintiff, Dr. O'Brien, did discuss some of the cases, but they were largely confined to some of the cases cited by Dr. Loeber. They were supportive of the plaintiff in most respects, but they were critical about some aspects of her practices. Dr. Wender's testimony was essentially unchallenged. Dr. Heller was asked by the committee to return for cross-examination relating to the quality-of-care issue. He did not return, even though he lives in the Chicago area, unlike Dr. Wender, who came from Los Angeles. Plaintiff testified, although not at length. It was a confrontational and emotional session. It did little to further the committee's understanding of the quality-of-care issue.

The failure to explore the cases continued after this suit was filed. We so noted in our memorandum and order of March 8, 1994, in which we refused to require Dr. Wender to submit to further depositions. Finally, in response to the motion for summary judgment plaintiff filed an extensive affidavit of Dr. Heller. That led to a lengthy deposition. Dr. Heller dealt with many, although not all, of the cases cited by Dr. Loeber, and he focused on

his disagreements, rather than his agreements, with Dr. Loeber.

Dr. Heller's affidavit and deposition provide support for the conclusion that, on some cases, Dr. Loeber was just plain wrong; she misread the charges, or thought certain action should have or should not have been taken, and Dr. Heller disagreed. As to others, he did not credit CRNA incident reports. He several times made the point that the written medical records do not tell the whole story and, after discussing the cases with Dr. Vakharia, he believed that she had acted appropriately in situations that could only be fairly evaluated by those who were in the operating room at the time. His analyses did not extend, at least in any substantial respect, to the cases reviewed by Dr. Wender and Dr. Blancato, and not by Dr. Loeber.

Perhaps if Dr. Heller had so testified at the hearing, the outcome would have been different. Perhaps the committee, on the basis of that testimony, might have insisted on hearing further from Dr. Loeber and Dr. Wender. But at the time of the hearing it had before it the testimony of Dr. Loeber, which was very incompletely challenged. This is not a case in which an employer relies, without investigation, upon the account of some supervisor, who, it later turns out, was providing a false story. Dr. Loeber testified. Plaintiff could and did cross-examine. The likelihood that a witness would deliberately misread medical charts is remote since any errors could be exposed on cross-examination. More importantly, the testimony of Dr. Wender, an independent outside consultant with excellent credentials, was largely unchallenged. He was prepared to discuss the cases, which he had reviewed prior

to his testimony, and his conclusions remained unchanged. In those circumstances it is not at all surprising that the committee reached the conclusion it did.

The committee "strongly and unanimously" recommended that the suspension be affirmed. It rested primarily upon the ASA Report and Dr. Wender's testimony, noting that Dr. Loeber's testimony "essentially confirmed the ASA's findings. . . . " The committee concluded, on the basis of the hearing, that Dr. Vakharia "was incapable of accepting constructive criticism and either incapable or unwilling to address those criticisms. . . . [D]uring the proceedings, she frequently evaded directly answering questions from Committee members about the Committee's areas of concerns . . . Dr. Vakharia's responses to the Hospital's questions were argumentative, evasive and incredible. . . . Unfortunately, Dr. Vakharia and her various representatives seemed more intent on arguing 'procedural' questions than addressing relevant substantive quality of care issues." The committee recognized the qualifications of plaintiff's experts but was critical of their failure to address specific cases. All of those observations have ample support in the hearing record.

The Medical Executive Committee accepted the report on May 9, 1990. Plaintiff asked for appellate review and the Board of Directors appointed an appellate review committee, which submitted a 21-page report on September 7, 1990, affirming the suspension. While its tone is somewhat harsh at times, its conclusions have ample support in the hearing record.

This court does not, of course, sit as a super personnel review authority. We cannot judge whether or not

plaintiff provided substandard care, nor are we asked to do so. It is indeed possible that the hearing committee got it wrong. There is, however, nothing to suggest that the hearing committee was motivated by racial (and, if we consider Title VII and the ADEA, gender or age) discrimination and that it acted on other than the record created during those extensive hearings. The review process relied upon that record and, as we have said, the subsequent conclusions are amply supported by that record. Again, there is no evidence suggesting discrimination. Defendants are entitled to summary judgment on the issue of whether plaintiff's suspension was the result of discrimination.

That leaves open a number of issues relating to the events leading up to the suspension and hearing. We note, first, that the statute of limitations for a § 1981 or § 1985 claim is two years. This action was filed on November 8, 1990. We therefore must keep in mind what plaintiff challenges that occurred before November 8, 1988, and what happened later. Earlier claims of discrimination, if supported by the evidence, can lend support to discrimination claims within the statutory period even though they cannot stand as independent claims.[2]

Plaintiff claims that Dr. McCormick brought in Dr. Loeber to be his instrument to eliminate the Asian female anesthesiologists over the age of 40 as part of a plan going back to 1984. She does not explain why the hospital

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[2] Plaintiff raises some "continuing violation" contentions. While we do not believe they have merit, we do not specifically deal with them because limitations issues do not affect the ultimate result.

– where approximately half the medical staff was educated abroad – would single out the relatively small number of anesthesiologists for discriminatory treatment. While she treats race or national origin, gender and age as separate bases of discrimination, her main thrust is a combination of race or national origin and gender, as well she might, since of the other three anesthesiologists, apart from Dr. Loeber and the three Asian women, one was a woman and one was a Burmese male. We note, as well, that in July 1997 five of the eight anesthesiologists were foreign-born or -educated, and five were women. Plaintiff is correct in contending that the record fully supports the conclusion that Dr. Loeber, early in her role as head of anesthesiology, targeted the three Asian females over 40 as persons she did not want to continue on the staff. But does the record provide sufficient evidence that she was motivated by discrimination? We think not.

Dr. Loeber was introduced to staff in November or December 1985, and began work in April 1985. According to plaintiff, Dr. Loeber's credentials were unimpressive, she was paid far more than others similarly situated, and she did not do much other than aggrandize her own position at the expense of others.[3] Despite plaintiff's perceptions, however, we believe that it is beyond reasonable dispute that Dr. Loeber came to the hospital because of a concern over the quality of the anesthesiology services and that she was charged with the upgrading of

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[3] Plaintiff is alone in her perception that Dr. Loeber did virtually nothing about improving quality of care, as the ASA Report pointed out. That report also pointed out some weaknesses in her administration of the department.

those services. (We do not pass judgment on whether she was the right person for that endeavor, as that is irrelevant for the purposes of this motion.) Those services had been part of the department of surgery, with quality assurance review through that department. Anesthesiology became a separate department in 1986, with Dr. Loeber as the chair. Early in 1986 Dr. Chookaszian joined the department. Dr. Loeber described her as "all-American, blonde, with blue eyes and has a funny last name."

By the middle of 1986 the amount of work for the physicians in the department had decreased. Dr. Loeber suggested that the physicians go on part-time status so as to permit them to get lower insurance rates (which the physicians paid). Plaintiff sought the lower rate, but it was denied because she was still at the hospital five days a week. On March 27, 1987, Dr. Loeber wrote plaintiff about the thirteen cases. Dr. Loeber has testified that she asked plaintiff for a response several times thereafter but received no response, which plaintiff denies. About that time Dr. Konowitz, a white native male, joined the staff. Eventually, though, in August 1987, Dr. Loeber wrote to plaintiff asking for a response, and plaintiff did so respond the following month. About this time – some evidence indicates – Dr. Loeber began to weight the assignment system against the three Asian women. In September 1987 plaintiff asked that her work be consolidated into two or three days a week so as to make her eligible for reduced insurance rates. At that time she described the request as due to family responsibility and thanked Dr. Loeber when the request was accommodated, effective October 1, 1987. The hospital contends that the request was due to the quality-of-care issues that were

then surfacing. Plaintiff now describes it as a reaction to emerging discrimination. Whatever the reason in plaintiff's mind, it is clear that the schedule reduction was at her request and not compelled by the hospital. Also during that time-frame, in August 1987, plaintiff concedes that Dr. Loeber established quality control procedures not previously in place, although plaintiff characterizes them as largely the work of others. While she was working part-time plaintiff claims that her cases were substantially reduced in number and in value. She continued on rotation, however, with the result that she continued to work on a variety of complex cases.

In January 1988, Dr. Loeber instituted a new assignment system. The anesthesiologists were divided into three classifications: Dr. Loeber, senior anesthesiologists, and junior anesthesiologists. Plaintiff and the other two Asian females were the juniors, and the other three, who included Dr. Myint (a male Burmese) were the seniors, even though one of the qualifications for senior status was board-certification and plaintiff was board-certified, and one of those designated as senior was not. Dr. Loeber dropped the board-certification as a requirement for senior classification in April 1988. The seniors were supposed to handle the more complex cases and the juniors the more routine, although the dynamics of rotation and emergencies caused the juniors to continue to serve in many complex cases.

On March 31, 1988, Dr. Loeber wrote various of the surgeons asking for their preferences among the anesthesiologists. Plaintiff claims that only 35 of 71 surgeons were surveyed and only some responded. Of those that did, plaintiff was least, or close to least, preferred. About

that time Dr. Loeber advised the staff that she and the seniors had priority in assignment of *all* cases and she began to leave plaintiff messages about assistance in finding work elsewhere.

In June 1988 plaintiff notified Dr. Loeber that plaintiff was resuming a full-time schedule. According to plaintiff the part-time status was temporary and for personal reasons, a matter within plaintiff's control. It was and is plaintiff's position that a denial of full-time status is a reduction in privileges which only the Credentials Committee could compel. It was and is the hospital's position that the issue is one of assignment, and Dr. Loeber had the authority to make assignments based upon her perception of relative competency. When Dr. Loeber refused to return plaintiff to full-time rotation, she complained to both Dr. Trakas and the MEC. The MEC, as we said, upheld Dr. Loeber on the assignment issue and began looking around for help in resolving the quality-of-care issue. In the meantime, plaintiff actively solicited support from various surgeons on staff and complained of discrimination sufficiently to prompt the hospital's attorneys to predict that plaintiff would bring a discrimination charge. Dr. Loeber, during this period, broadened her review of plaintiff's cases (the 66 or 67 cases), and Dr. McCormick suggested to plaintiff that she retire in order to avoid airing "dirty laundry."[4] Thereafter, plaintiff also actively solicited work from, as we understand it, primarily foreign-born and trained surgeons, suggesting that she was the victim of discrimination. Although she had

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[4] Plaintiff labels that remark as discriminatory. We disagree.

been taken off call in July 1988, that solicitation led, for a time, to plaintiff having more work than she could handle. Plaintiff's response also led to her initiating a review of the operating records of the other anesthesiologists, which prompted complaints about her unauthorized review of those records and restrictions upon her access to Dr. Loeber's office, where, apparently, at least some anesthesiology supplies were maintained. The ASA review and the hearing followed.

As we have said, the record provides solid support that Dr. Loeber wanted the three Asian women to leave. It does not support a discriminatory motivation. She was brought in to upgrade anesthesiology services. It was some time before she made any assessments, after she had had considerable time to observe the work of the staff. She concluded that the three Asian women were not up to the standard that she thought the hospital believed appropriate. Her view of plaintiff was ostensibly based in part upon her consideration of thirteen occurrence reports. Those were not in the normal course of quality assurance review, which would have provided for contemporaneous assessment, but that review of past reports was wholly consistent with the assignment she had been given. Perhaps Dr. Loeber verbally asked plaintiff to respond and perhaps she did not. What we do know is that plaintiff ignored the matter until directed in writing some five months later to respond, and when she did, the response was handwritten and mostly blamed nurse Filipowski for filing false reports and asked that the nurse be investigated. Dr. Loeber had reason to consider the response hostile and, at least partially, vague and nonresponsive.

Dr. Loeber's initial perception of all three anesthesiologists was vindicated by the ASA Report. Two of the three did not contest the ASA's recommendation and did not remain at the hospital. As we have said, we do not here pass judgment on Dr. Loeber's conclusions respecting those thirteen cases, or the 66 or 67 others, but we do not believe a reasonable trier of fact could find that her perceptions of plaintiff's competency were not honestly held. Her review of the records was substantiated by the physicians' survey (imperfect though it may have been), plaintiff's reaction to criticism, the ASA records review and its report on the assessment of others within the hospital that she " 'dumped' extremely ill patients in the recovery room and then became unavailable" (although that had improved), and that "many surgeons, nurses, and CRNAs described her care under the pressure of difficult situations as being erratic and oftentimes extremely poor." Even Dr. Heller conceded that the medical charting on occasion was far from ideal. Dr. Loeber's one remark about Dr. Chookaszian may not have been politically correct, but it cannot reasonably be viewed as evidence of discriminatory motivation,[5] and her hirings (three, with one there only a few months) were so restricted that they cannot, without more, lend support to plaintiff's claim.

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[5] Plaintiff relies on two other remarks supposedly by Dr. Loeber. One is hearsay. The other is referenced to a statement by a nurse (Pl.Exh.G). It is not there.

Summary judgment is entered as follows:

1. For SCH and against plaintiff on Count I because SCH is not plaintiff's employer and, if it was, SCH is entitled to summary judgment on the merits.

2. For SCH and Dr. Loeber and against plaintiff on Count II.

3. For SCH and against plaintiff on Count III, for the reasons stated with respect to Count I.

4. For the named defendants and against plaintiff on Count V.

5. For SCH and the MEC defendants and against plaintiff on Count VII for the reasons stated with respect to Count I and for Dr. Loeber and against plaintiff on the merits. Dr. Loeber's possible status as an employer has not been addressed by the parties.

That leaves, then, Count IV, a state law claim, and Count VI, a Sherman Act claim. We address them, beginning with Count VI.

On March 30, 1993, this court ruled that a Sherman Act conspiracy claim against certain defendants survived a motion to dismiss because the suspension of privileges arguably had a wider impact than just at SCH. This led to a motion for reconsideration in October of that year, and another such motion in January 1995. Rulings were deferred. Today we consider those motions to dismiss as motions for summary judgment and we grant them.

Ordinarily a court should not consider a motion to dismiss as a motion for summary judgment without giving the plaintiff an opportunity to respond. But this is not

an ordinary case. Plaintiff, in opposition to the various motions for partial summary judgment and in support of her motion, has called attention to every conceivable matter that she believes may lend support to her contention that her suspension was due to reasons other than quality-of-care issues, and we have reviewed all of her contentions. We see no reason to wait for an inevitable motion with an inevitable result.

The antitrust claim always was marginal. Perhaps defendants are correct in their legal analysis. In any event, we begin by wondering why the ASA, Dr. Vacanti (whose role was limited to selecting the survey team and, apparently, reviewing the draft ASA Report) and the survey team of Dr. Blancato and Dr. Wender would have any interest in eliminating competition by plaintiff. Dr. Loeber, Dr. Chookaszian, Dr. Myint and Dr. Konowitz had an interest in the anesthesiology business at SCH, but only Dr. Loeber was involved in the suspension of plaintiff's privileges. She could not conspire with herself; there is a total absence of any evidence of any conspiracy between her and ASA or the ASA defendants, or between those defendants and the other anesthesiologists at the hospital. Indeed, Dr. Loeber tendered her resignation long before the ASA Report and it became effective about the time the ASA Report was issued and plaintiff was suspended. The motions to dismiss Count VI, considered as motions for summary judgment, are granted.

Count IV raises other considerations. It is a state law claim. Ordinarily, if a court rules against a plaintiff on all federal claims short of trial, the pendent state law claims are dismissed without prejudice. Plaintiff may then pursue those claims in state court. But 28 U.S.C. § 1367 does

not compel dismissal. *Rothman v. Emory University*, No. 93 C 1240, 1996 WL 377049 (N.D.Ill. July 1, 1996), *aff'd* 123 F.3d 446 (7th Cir.1997). This court has immersed itself in this case for longer than it cares to remember. We see no purpose to be served by inflicting upon the parties and a state court the resolution of the state claims, which require some familiarity with a massive record, if we can resolve it here. And we can.

Count IV complains that the hospital violated the Medical Staff Bylaws in a number of respects. She alleges twelve violations in paragraph 59:

> (a) applying the Bylaws so as to discriminate against Dr. Vakharia on the basis of her race, color, national origin, and sex;
>
> (b) creating two levels of staff anesthesiologists and assigning Dr. Vakharia and the two other female Asian anesthesiologists to the lowest level of staff within the department;
>
> (c) treating Dr. Vakharia disparately with regard to case assignments and positions within the anesthesiology department when she held full staff privileges as a member of the department and was the only member of the department besides Dr. Loeber who was both Board Certified and a member of the Attending Staff;
>
> (d) allowing Dr. Loeber to exercise authority concerning the administration of the department and staff privileges which the Bylaws reserves to the Credentials Committee and to the Medical Staff Executive Committee;
>
> (e) restricting Dr. Vakharia's rights and privileges as a member of the staff of the anesthesiology department in a manner inconsistent with

the Bylaws, and denying Dr. Vakharia notice and a hearing on those restrictions;

(f) singling out Dr. Vakharia disparately and discriminatorily for peer review;

(g) allowing Dr. Loeber to serve on the Ad Hoc Committee that reviewed Dr. Vakharia's complaints about Dr. Loeber's treatment of her;

(h) suspending Dr. Vakharia disparately, discriminatorily, and for improper purposes;

(i) failing to conduct a hearing on Dr. Vakharia's suspension in a timely manner;

(j) allowing physicians who were complainants against Dr. Vakharia or whose own cases were reviewed by the Hearing Committee to serve on that Committee;

(k) failing to conduct the peer review process in accordance with the Bylaws and the Illinois Medical Practice Act; and

(l) conducting its peer review process so as to discriminate against Dr. Vakharia on the basis of her race, color, national origin, and sex and to deny her the protections required by the Bylaws.

We turn, first, to the alleged violations relating to the summary suspension. Plaintiff's concerns, as described in her various submissions, range well beyond those alleged. She contends that the matter should have gone to the Credentials Committee, that the membership on the ad hoc hearing committee was rigged because Dr. McCormick became involved and because all the members were men and only one (Dr. Ovieda) was foreign-born, that various of the members were biased against her because

of prior involvements with her, that the selection of the hearing officer was rigged, that the notice provided was insufficient, that the committee forced out her attorney and allowed attorneys for the hospital to participate in the proceedings, that her cross-examinations were curtailed, that she was prejudiced because the ASA would not permit her intended experts to testify for her, that the committee refused to hear evidence about discrimination and the quality of care of other anesthesiologists, that there was a long delay before the hearing commenced, that the ASA Report upon which the committee relied was obviously shallow and insubstantial because of time restraints, and that neither the ASA review nor the hearing was a peer review.

Running through all her contentions is the ultimate conclusion that the hearing was a sham proceeding intended to remove her from the hospital because she was an Asian woman. We have already determined that the record does not support such a conclusion. But are there specific matters that could justify relief under Illinois law? That requires a consideration of Illinois law.

Illinois law, both cases and statutes, reflects a significant hesitation about intruding into the peer review process. Judicial review of a suspension is limited to determining whether there has been a substantial violation of the bylaws or whether the record establishes actual unfairness in the proceeding. *Adkins v. Sarah Bush Lincoln Health Center*, 129 Ill.2d 497, 136 Ill.Dec. 47, 544 N.E.2d 733 (1989). As the facts in *Adkins* make clear, peer review under Illinois law includes the review of a single physician. *See also Harris v. Bellin Memorial Hosp.*, 13 F.3d 1082 (7th Cir.1994). In a hospital setting it is inevitable

that the members of the committee will have had prior involvement with the physician being reviewed and may even have general personal views about that physician's level of competence, but they can make the decision unless the record discloses actual bias. *Id.; Chessick v. Sherman Hospital Association*, 190 Ill.App.3d 889, 138 Ill.Dec. 98, 546 N.E.2d 1153 (1989); *Lapidot v. Memorial Medical Center*, 144 Ill.App.3d 141, 98 Ill.Dec. 716, 494 N.E.2d 838 (1986); *Ladenheim v. Union County Hospital District*, 76 Ill.App.3d 90, 31 Ill.Dec. 568, 394 N.E.2d 770 (1979). Even if the suspension is in substantial violation of the bylaws or is demonstrably unfair, the only remedy is to order compliance, not reinstatement. *Carson v. Northwest Community Hospital*, 192 Ill.App.3d 118, 139 Ill.Dec. 194, 548 N.E.2d 579 (1989); *Gates v. Holy Cross Hospital*, 175 Ill.App.3d 439, 124 Ill.Dec. 897, 529 N.E.2d 1014 (1988). There is no damages remedy against either the hospital or the individuals who participated in the decision, even though that restriction on remedies may work an occasional injustice. *Knapp v. Palos Community Hospital*, 176 Ill.App.3d 1012, 126 Ill.Dec. 362, 531 N.E.2d 989 (1989).

The medical staff bylaws provide that, upon suspension of privileges by the chief executive officer (Dr. McCormick), the Medical Executive Committee shall recommend within one week whether or not the suspension shall continue. If the MEC recommends continuation (and it is continued), the MEC shall specify to the physician that she has ten days to request a hearing or an appellate review. If she requests a hearing it is supposed to commence within ten days of the request. The hearing is to be conducted by an ad hoc committee of not less than five

members of the medical staff appointed by the president of the medical staff (Dr. Trakas), in consultation with the MEC. No member can have "actively participated in the consideration of the adverse recommendation." Postponement of the hearings shall be made only with the approval of the ad hoc hearing committee and shall only be for good cause shown and in the sole discretion of the hearing committee. Neither the physician nor the hospital has a right to be represented unless the committee permits both sides to be represented. The rules of evidence do not apply. The physician may be accompanied by a colleague or another physician and has to present her side by cross-examination and her own evidence.

Plaintiff contends she was suspended on June 30, 1989, when Dr. McCormick told her not to provide services. The hospital contends that her privileges were not formally suspended until much later and, within ten days, the MEC on August 1, 1989, recommended continuation. Perhaps there was a technical violation (although probably not, as we will later explain). No Illinois court has, however, suggested that a hearing be repeated several years later because the process initially got off to a slow start and we do not subscribe to such a nonsensical result.

Plaintiff did request a hearing and an ad hoc committee was appointed by Dr. Trakas. Plaintiff complains that Dr. McCormick and others tried to influence the selection, and it is apparent that he wanted a solid committee – plaintiff had already filed her E.E.O.C. charges – but it was Dr. Trakas who named the members with, apparently, some distress over Dr. McCormick's attempt to be involved. None of the members had actively participated

in "the adverse recommendation," i.e., the Medical Executive Committee recommendation. Some of the members had been the surgeon on one or two cases included in the Dr. Loeber case lists (or the cases included in the ASA review), one had participated in the decision the previous year to leave assignments to Dr. Loeber as the department chairman and to request an outside review, and one had a previously-developed (but not expressed) concern about plaintiff's competence in the more difficult, complicated cases. On the other hand, another member had spoken up for her the previous year when she sought to return to full-time practice. While the panel was all male and only one was foreign-born, we reject the notion that women and more foreign-born physicians had to be on the committee to provide a fair hearing. The members were not selected in violation of the bylaws, none of their past involvement disabled them from serving, and the record of the hearing is absolutely devoid of any showing of actual unfairness or bias.

The hearing was slow in starting. First scheduled to begin September 18, it did not get under way until November 3. One reason was the inability of one member to serve, necessitating selection of another. The committee itself had some difficulty coordinating scheduling. But the hearings did commence – and went on until April. A technical violation? Possibly.

Plaintiff did not get a hearing officer who had been suggested by her. The hearing officer selected was appropriately qualified, had no close ties to the hospital and, the record reflects, acted fairly and impartially. Neither plaintiff nor the hospital (actually, the executive committee) were represented by counsel, although both were

entitled to have counsel present to provide advice. Plaintiff's counsel had an exchange with one of the committee members at one point and did not return. Plaintiff's counsel could be (and was) contentious, as we noted in our memorandum and order of March 8, 1994, the member apologized, and the committee invited plaintiff to have that attorney return. She did not have him return. The hospital attorneys did stay. Their participation was very limited.

Before the hearing began plaintiff, on September 1, 1989, was provided a notice of hearing that specifically described the deficiencies noted in the ASA Report, provided a copy of the ASA Report except for the portions dealing with the other two anesthesiologists, listed 67 cases reviewed by Dr. Wender and Dr. Blancato, and noted that plaintiff had copies of those medical records.

Plaintiff had asked Dr. Ivankovich to be her expert. But he was an officer of ASA, and ASA, not the hospital, asked (not demanded) that he not undertake that responsibility because of a perceived conflict of interest since a centerpiece of the hearing would be the ASA Report. He agreed. Likewise, three other ASA officers or peer review committee members turned plaintiff down. We see no transgressions there. Indeed, as we have remarked before, given plaintiff's proclivity for ascribing base motives to those who do not entirely share her views, an ASA officer who did not fully support plaintiff's perceptions of her own quality of care would have done so at his peril. Available to plaintiff as experts was the whole universe of anesthesiologists other than that small group. Plaintiff enlisted the services of Dr. Heller months before he was to testify.

Dr. Wender was at SCH only two days and Dr. Blancato only a day and-a-half. They had, however, considerable material to review before they arrived and they had additional material supplied to them after they left. Plaintiff talked to Dr. Wender for one and-a-half to two hours and she later supplied him with numerous records pertaining to the other anesthesiologists. She is correct that the ASA review was not a full review of all the anesthesiologists in the sense that the reviewers considered substantially the same number of records for each anesthesiologist. The hospital, after all, had asked for recommendations about certain anesthesiologists, including plaintiff. Still, they did some comparative reviewing, although whether or not they had access to all the questionable cases of the others is in dispute. Plaintiff certainly tried to make those records available to them.

More importantly, however, is that the hearing was about plaintiff's quality of care. The committee was entitled to focus on that, and it did so. And in doing so we see no substantial violations of the bylaws and no unfairness. We grant summary judgment for the hospital and against plaintiff, on the state law medical staff bylaw claims relating to the suspension.

That leaves state law claims relating to events preceding the suspension. Plaintiff complains that she was twice passed over for appointment as chair, that she was "forced" to restrict her work to part-time, that she was taken off rotation in July 1988, that she was denied return to full-time status, and that she was classified as a junior when Dr. Loeber created the "senior-junior" status. Although she claims that she continued to handle many complicated cases, at least up to going off rotation in

1988, she claims that her income was adversely affected by a reduction in cases and change in her mix of cases.

Plaintiff bases these claims on alleged violations of the medical staff bylaws, viewed as a contract between her and the hospital. *Fahey v. Holy Family Hospital*, 32 Ill.App.3d 537, 336 N.E.2d 309 (1975), *cert. denied*, 426 U.S. 936, 96 S.Ct. 2650, 49 L.Ed.2d 387 (1976). She cannot base her claims upon some specific contract between her and the hospital, as there was none. Indeed, the contract between Dr. Loeber and the hospital granted her the authority to make case assignments, and it is case assignments that are the core of these claims by plaintiff. But can these claims be viewed as possible medical staff bylaws violations? Failures to appoint plaintiff as chair possibly can be viewed as such, although she did not ask for a hearing on those claims, and they have long since been waived. That is also true of her other claims, with the possible exception of her removal from rotation and failure to return her to full-time status in 1988 – and maybe the "senior-junior" classification.

SCH insists that plaintiff was not returned to full-time status in 1988 because there was not enough work for the anesthesiologists if plaintiff was given more cases – or so Dr. Loeber believed. Quite possibly this is so, but plaintiff disputes that, and we cannot, on the present record, conclude that the hospital is indisputably correct. By then the quality-of-care issue had long since surfaced and the "senior-junior" classification was in place. The ASA Report clearly concludes that the "senior-junior" classification implicates the medical staff bylaws.

Still, we are mindful that there is a significant difference between privileges and employment. *Bryant v. Glen Oaks Medical Center*, 272 Ill.App.3d 640, 208 Ill.Dec. 928, 650 N.E.2d 622 (1995). Privileges relate to qualifications, while employment is a matter of contract, *Faucher v. Rodziewicz*, 891 F.2d 864 (11th Cir.1990); *Collins v. Associated Pathologists, Ltd.*, 844 F.2d 473 (7th Cir.1988). That there may have been a practice of equalizing assignments does not create an employment obligation, *Knapp v. Palos Community Hospital*, 125 Ill.App.3d 244, 80 Ill.Dec. 442, 465 N.E.2d 554 (1984), *app. after remand*, 176 Ill.App.3d 1012, 126 Ill.Dec. 362, 531 N.E.2d 989, (1988), *app. denied*, 125 Ill.2d 566, 537 N.E.2d 810, 130 Ill.Dec. 481 (1989), Dr. Paulissian, testifying for plaintiff, recognized that Dr. Loeber could make assignments based on perceptions of relative competency and Dr. Heller agreed that assignment by a department head on that basis was a common and accepted practice.

Even if we assume, however, that the "senior-junior" classification was a violation of bylaws, plaintiff still does not prevail. We have already noted the reluctance of the Illinois courts to intervene in disputes relating to hospital staffing judgments and that even when the issue is reduction of privileges the sole remedy is another hearing. Judicial review of assignment practices is even more intrusive, and plaintiff points to no Illinois case that provides support for the view that restrictions upon a physician's practice, short of the suspension of privileges, triggers judicial review. The only possible exception is *Fahey, supra*, but there the hospital conceded that a rule implicated the bylaws and the court held that the rule was permissible even absent a hearing.

If we were to direct that a hearing be held that related to case assignments prior to the suspension, we would, in effect, be requiring the hospital to reconsider its assignment practices several years ago, without any possible economic benefit to plaintiff. We are not aware of any Illinois law so requiring, and, as a federal court sitting in diversity, we should not be creating remedies not sanctioned, with reasonable clarity, by that controlling law. Indeed, the most analogous Illinois Supreme Court case. *Adkins, supra,* strongly suggest [sic] by implication that the upholding of a suspension wipes away any claims peripheral to the suspension claim. We grant summary judgment for the hospital and against plaintiff on Count IV.

The case began with a suspicion arising from the separation of all three of the Asian women anesthesiologists from the hospital. Despite massive discovery the discrimination claim has never advanced beyond suspicion, and it was that claim that has been the core of this lawsuit. If a plaintiff can prove the articulated cause of privileges suspension, concerns about quality of care, is a pretext, the trier of fact has some latitude in inferring that the real motive was discriminatory, *Anderson v. Baxter Healthcare Corp., supra.* But here plaintiff has not come up with evidence that would permit a reasonable trier of fact to conclude that the articulated cause was a pretext. We cannot know with certainty what various people may have thought. It is not enough, however, to raise the possibility that the suspension of privileges may have been the result of base motives when the evidence corroborates the reasons given. Plaintiff has the burden of proving her case by a preponderance of the evidence, and

that means something beyond "maybe" and "perhaps." We grant summary judgment for the defendants and against plaintiff on the remaining counts of the complaint. We deny plaintiff's motion for partial summary judgment.

United States Court of Appeals
For the Seventh Circuit
Chicago, Illinois 60604

December 7, 1999

Before

Hon. Richard D. Cudahy, *Circuit Judge*
Hon. John L. Coffey, *Circuit Judge*
Hon. Diane P. Wood, *Circuit Judge*

USHA VAKHARIA, M.D., *Plaintiff-Appellant,*	Appeal from the United States District Court for the Northern District of Illinois,
No. 97-4235 v.	Eastern Division
SWEDISH COVENANT HOSPITAL, AMERICAN SOCIETY OF ANESTHESIOLOGIST et al.,	No. 90 C 6548
Defendants-Appellees.	James B. Moran, *Judge*

ORDER

On consideration of the petition for rehearing and correction with petition for rehearing *en banc* filed on September 23, 1999, in the above-captioned case by plaintiff-appellant, no judge in active services has requested a vote thereon and all of the three judges on the original panel have voted to deny rehearing.

Therefore, the petition for rehearing *en banc* is DENIED.

No. 97-4235

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

USHA VAKHARIA, M.D. Plaintiff-Appellant, vs. SWEDISH COVENANT HOSPITAL, et al. Defendants-Appellees.	)	On appeal from the United States District Court For The Northern District of Illinois, No. 90 C 6548 The Honorable James B. Moran Judge Presiding

PLAINTIFF-APPELLANT'S PETITION FOR REHEARING AND CORRECTION WITH SUGGESTION FOR REHEARING EN BANC

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TABLE OF ABBREVIATIONS

Abbreviation	Explanation
DK#	Docket Number
RF	Bates Number Code for Exhibits to Plaintiff Response to Defendants Statement of Uncontested Facts
SA	Supplemental Appendix
SSA	Second Supplemental Appendix Tab Number
SCF	Bates Number Code for Documents produced in Discovery by the Defendants

PETITION FOR REHEARING AND CORRECTION WITH SUGGESTION FOR REHEARING EN BANC

Plaintiff-appellant, Usha Vakharia, M.D., suggests that a rehearing *en banc* is necessary to maintain uniformity of decisions of this court. This opinion conflicts with an earlier opinion in this circuit, *Memorial Hospital For McHenry County* v. *Shadur,* 664 F.2d 1058, (7th Cir. 1981) and with opinions which have been rendered in other circuits, those being *Miller* v. *Indiana Hospital,* 843 F.2d 139 (3rd Cir. 1988), *cert. den.,* 488 U.S. 87 (1988); *Bolt* v. *Halifax Hospital Medical Center,* 891 F.2d 810 (11th Cir. 1990) *cert. den.,* 495 U.S. 924 (1990) and *Brown* v. *Presbyterian Health Care Service,* 101 F.3d 1324 (10th Cir. 1996) *cert. den.* 137 L. Ed.2d 564 (1997).

I

THE COURT DID NOT CONSIDER THE COMPARATIVE EVIDENCE OFFERED BY THE PLAINTIFF

While the court mentions the "familiar burden-shifting method of *McDonnell Douglas Corp. v. Green*, 411 U.S. 792 (1973)" (p. 10), the framework which it has followed is to treat peer review as the end of the line in medical discrimination cases even where evidence of discrimination was specifically barred at the hearing (DK#572, p. 121-6, 534-41, 684, 1184-85, 1812-14, 3004-6; SA2, ¶ 547-53).[1] It has acted on the premise that in a professional setting, the ordinary rules pertaining to proving a case of discrimination do not apply. In a discrimination case – a "disparate treatment" case – the plaintiff bears the burden of proving that persons in the protected class are treated less favorably than persons in the favored class. By definition, comparison is involved.[2] As a discrimination case brought on for hearing on summary judgment, the question is whether there is a genuine issue of material fact as to whether the plaintiff was treated less favorably than persons in the favored class under similar circumstances, *Stumph* v. *Thomas & Skinner, Inc.*, 770 F.2d 93, 97 (7th Cir. 1985); *Dey* v. *Colt Constr & Development Co.*, 28 F.3d 1446, 1458 (7th Cir. 1994). The plaintiff has offered proof that her performance, when

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[1] *Pinhas* v. *Summit Health, Ltd.*, 894 F.2d 1024, 1030 (9th Cir. 1989) *aff'd* 500 US 322 (1991) interpreting *Patrick* v. *Burget*, 486 U.S. 94 (1988) held that a peer review is not a bar to suit on the merits.

[2] Judge Shadur's ruling in this case (SA3).

measured against members of the favored class, is superior (SA8, DK#497). As this court noted (p. 14), Drs. Heller and O'Brien testified before the peer review committee that Vakharia "generally met the requisite standard of care."[3] But in addition, Dr. Heller reviewed all cases performed by the so-called "seniors" that were sent to the American Society of Anesthesiologists (ASA) for review and noted the deficiencies based on the standards used in reading Vakharia's record (Id.). His "case specific" affidavit concluded not only that Dr. Vakharia's care was within the standard of care for anesthesiologists but that "the general level of care furnished by the so-called 'senior' anesthesiologists demonstrate more serious problems with anesthesia care than any of the problems allegedly related to Dr. Vakharia's care." (Id.) Dr. Heller's affidavit was not contradicted (DK#532, 543). No comparative evidence was offered by the ASA or any of the defendants (Id.). Indeed the plaintiff's entire 12(n) statement was not answered by the defendants (Id.). If anyone should have received summary judgment, it should have been the plaintiff.

Instead of whether there is evidence of discrimination, this court states, p. 3, "The key issue on appeal is whether Vakharia was meeting SCH's legitimate performance expectations (the second element of her prima facie case)."[4] In making its decision, the court notes that it does "not sit as a super-personnel department that re-

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[3] Heller and O'Brien's criticisms of Vakharia primarily related to recordkeeping and not clinical competence.

[4] ASA Procedures requires a comparative analysis (DK#503, RF 593 et seq.).

examines an entity's business decisions." It states p. 11, that "Since our task is to focus on the honesty of the committee's explanation for its recommendation that Vakharia's privileges not be renewed (citation), *our inquiry is necessarily limited to the evidence that the committee actually had at its disposal.*" (Emphasis added).[5] This opinion is in conflict with this Circuit's opinion in *Memorial Hospital For McHenry County* v. *Shadur*, 664 F.2d 1058, (7th Cir. 1981), decided *per curiam*. In that case the plaintiff physician claimed that the peer review was a sham intended to implement a restraint of trade by a group of physicians. The court held that the hospital had to produce its records of the other physicians, stating, p. 1063, "To prove this allegation, Dr. Tambone must present evidence that other physicians with comparable or worse records than his were not denied staff privileges." If the peer review process was as sacrosanct as this court has made it in the instant case, then Dr. Tambone's comparative evidence was not admissible as opposed to being a prerequisite. Appellant suggests that there is no difference between Dr. Tambone's hoped-for comparison evidence and the case-specific actual evidence offered in this case.

Without mentioning them, this court has ruled contrary to opinions in other circuits which have held that a district court is not limited to considering the testimony before a peer review panel on the plaintiff's competency or adherence to the standard of care. In *Miller* v. *Indiana*

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[5] Magistrate Judge Weisberg ruled that the Medical Studies Act required the production of the records of other physicians at the hearings (SA 7).

Hospital, 843 F.2d 139 (3rd Cir. 1988) *cert den.* 488 U.S. 87 (1988), the court held that a physician bringing an anti-trust lawsuit was entitled to show that he was treated more severely than other physicians whose competence was in question but who presented no economic threat to the defendants even though a long peer review of the plaintiff resulted in the revocation of his privileges. The court declared, p. 144 fn 7, " . . . We explained that 'we do not doubt that a hospital could exclude an applicant from staff privileges either because he is not medically qualified or because of unprofessional conduct, *so long as the hospital applies the same standard to all applicants.*' (citation)." (court's emphasis). In *Bolt* v. *Halifax Hospital Medical Center,* 891 F.2d 810 (11th Cir. 1990), *cert. den.,* 495 U.S. 924 (1990) and *Brown* v. *Presbyterian Healthcare Services,* 101 F.3d 1324 (10th Cir. 1996), *cert. den.,* 137 L.Ed.2d 564 (1997), the courts held that even if the inquiry were limited to the good faith of the peer review process, a physician called as an expert witness by the plaintiff may testify subsequent to the hearing that no legitimate basis existed for charges of improper care made against the plaintiff in the peer review hearing. Dr. Heller's testimony at the *ad hoc* hearing (DK#572, p. 2524, 2525, 2530, 2551) and in his affidavit (SA8), and in his deposition (DK#578) is that Dr. Loeber's and Dr. Wender's testimony was not simply wrong but something no competent honest physician would say. At the hearing Drs. O'Brien and Nennhaus voiced similar conclusions and backed that up with specific examples (DK#72, p. 2677-78, 2718, 2093-4, 2024).

II

THE UNWILLINGNESS OF THE COMMITTEE TO HEAR COMPARATIVE TESTIMONY IS ITSELF EVIDENCE OF BAD FAITH

This court itself states, p. 13, "The issue here is whether the *ad hoc* committee – the primary decision-maker in this case – genuinely believed that the care she provided was inferior." (p. 13). To determine whether something or someone is "inferior" necessarily presumes a comparison. Yet, the committee refused to allow either the records of the other physicians to be made available for review before or at the hearing or to allow any comparison evidence (DK#572, p. 534-41, 1184-85, 1812-14, 2314, 3004-6). This court treats the situation as one in which its "hands are tied" even though that the committee, advised of the disparity of treatment, expressly and deliberately refused to allow any testimony by anyone which compared the care of Dr. Vakharia to anyone else![6] In *Debs* v. *Northeastern Illinois University*, 153 F.3d 390 (7th Cir. 1998), cited by the court on pages 11 and 12 there was no evidence of a comparative nature and no refusal to hear testimony. Even if "quality of care" were the only issue in the case (as opposed to discrimination and anti-trust activity), all of the experts in the instant case (SA8, ¶10), including Dr. Wender, recognized that comparison is at the heart of any true peer review. At the hearing Wender himself testified that it would be necessary to

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[6] It did allow Dr. Wender to give conclusory remarks about the superior care of the favored class of physicians but would not allow any testimony or questioning about specific cases of the favored physicians (DK#572, p. 186, 198, 202, 227, 233, 258, 263, 309, 313, 326, 357-8, 1167).

compare the work of a particular anesthesiologist with the work of the group because of the great variation in patients from one institution to another (DK#572, p. 356-58). He sought to justify what he did on the basis that it was not peer review (DK#572, 324-215). Dr. Terry Vitez, on behalf of the American Society of Anesthesiologists, wrote "Anesthesia Quality Assessment" (DK #503, RF593 et seq.) in which he explained that "Individual performance must be compared to the performance of physicians or nurses with similar practice profiles." The ASA itself initially turned down SCH when McCormick insisted that the review be limited to Vakharia and the other Asian physicians. After Wender and Blancato came to the premises, the ASA warned that what they did was not peer review. Dr. McCormick consciously avoided departmental review when it was specified as a requirement of peer review first by the ASA itself (DK#539, p. 241; DK#582, 10/5/93 p. 11-13) and then by Dr. Edward Brunner, an expert selected by the hospital's own lawyers who refused to participate unless the entire department was reviewed (SA2, ¶243).

In every other field of law, if a party, having been warned of the possibility of contrary evidence or of a specific danger, deliberately ignores that notice, he is held to the same standard as if he acted intentionally. A party who consciously avoids information which would inform him that he is ineligible to make the claim for payment by the United States government, will be held to have "knowingly" made a false claim if he proceeds. *United States* v. *Cooperative Grain & Supply Co.*, 476 F.2d 47, 60, 26 ALR Fed. 282, 298 (1973). " 'The intent to deceive of a fraudulent misrepresentation may include a reckless

disregard of the truth or falsity of the belief,' *Cooper* v. *Schlesinger,* 111 U.S. 148, 155 (1913)." If a writer publishes a story about a public figure after receiving notice that the story may be in error without investigating that information, he has the same liability as a person who intentionally lies about someone. *Harte Hanke Communications, Inc.* v. *Connaughton,* 491 U.S. 657, 692 (1989). "Although failure to investigate will not alone support a finding of actual malice (citation), the purposeful avoidance of the truth is a different category." (Id.) Now this court holds that ordinary inference of malice or wilful and wantonness not only does not apply but rather that a peer review committee which consciously and continuously seeks to prevent any testimony of a double standard after being told that it exists must be considered as a matter of law to have been acting in good faith in doing so! The thought is inescapable that the court has decided that any hearing passing under the rubric of peer review is an automatic bar to a subsequent claim of discrimination and antitrust activity.

III

THE COURT HAS GIVEN NO EFFECT TO LOCAL RULE 12

In reaching its decision, the court sets forth at some length the facts in this matter as it sees them. Many of the court's "findings of fact" are based on the defendants' 12(m) statement of facts, virtually all of which were disputed by the plaintiff (SSA1). The court has also not considered the facts in the plaintiff's 12(n) statements even though these went unanswered by the movant (SA2). This court reversed a summary judgment in *Brown*

v. *United States*, 976 F.2d 1104, 1108 (1992), noting, "Material facts that are set forth in the moving party's statement are deemed admitted unless they are controverted in the nonmoving party's response, Id. Rule 12(n) contributes to the orderly and efficient conduct of litigation, and we have repeatedly upheld strict application of the Rule."

In affirming summary judgment, the court acted as a trier of fact, resolving issues of credibility, crediting affidavits or peer review testimony of some persons while disregarding that of others. It has decided disputed questions of fact and has drawn inferences. But this court also does not sit as a trier of fact. In *Anderson* v. *Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986), the Supreme Court held with respect to summary judgment motions:

> Our holding . . . by no means authorizes trial on affidavits. Credibility determinations, the weighing of evidence, and the drawing of inferences from the facts are jury functions, not those of a judge. The evidence of the non-movant is to be believed, and all justifiable inferences are to be drawn in his favor.

IV

THE COURT OVERLOOKED THE CIRCUMSTANCES SURROUNDING CERTAIN FACTS

The court concluded that "Vakharia squandered ample opportunities to bolster her case before the committee" and attached considerable significance to the fact that the plaintiff "declined to exercise her right to testify on her own behalf" (p. 15). The court fails to note that the committee gave her 3½ days to complete her case. As this

court notes on page 14, the plaintiff had scheduled nineteen witnesses to testify on her behalf including the two independent experts.[7] They appeared during this period of time. As this court notes, p. 14, because they appeared, "The record is by no means devoid of evidence favorable to Vakharia" and "We think that the committee may have been unduly dismissive of the contribution of these professionals to an evaluation of Vakharia's work performance." The court failed to consider that the plaintiff asked for additional time repeatedly and her requests were denied (DK#556, Ex. 119). The plaintiff also submitted a case by case analysis in writing with supporting medical literature which refuted all of Loeber's and Wender's allegations and designated where in the medical records their testimony was demonstrated to be false (DK#503, Ex. 41A & B). None of the allegations of Wender and Loeber went unanswered. The court also criticized Vakharia's cross-examination of Drs. Loeber and Wender. As the court notes (p. 15), when Dr. Wender first appeared and was cross-examined by the plaintiff, he could not give answers on specific cases (DK#572, p. 303, 306, 307, 310, 313-15, 321-323-26, 328, 332). When he returned, the committee refused to allow the plaintiff to examine three large binders which contained what he had received from SCH plus his notes (DK#572, p. 1139, 1144, 1148-49). Plaintiff had no knowledge of any finding that Wender had made on any case and was told at 2:40 p.m. to cross examine him on all 43 cases then and there because he was not returning after that afternoon

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[7] In addition, one other witness, Perla Rigor testified for plaintiff.

(DK#572, p. 1134). Plaintiff wrote and asked him to tell her his findings (DK#503, Ex. 43A) but he would not comply. While Wender purportedly reviewed the cases of other physicians the plaintiff had been denied the right to examine him on any case of another physician (SA2, ¶548, 556). With 43 cases of her own and with no right to demonstrate the disparity in approach, the plaintiff chose instead to cross-examine him as to what investigations he conducted to arrive at the conclusions and findings in the ASA report. There would be many lawyers who could not handle the cross examination of a hostile witness on 43 separate medical cases in less than 6 hours with no opportunity to know, even at the time of examination, what this person had supposedly concluded and what he would offer in support. It is standard medical practice to give findings and the standard used in the evaluation with supporting literature in advance.

The court also gave weight to the fact that "the committee did not have the benefit of . . . Heller's expanded testimony"[8] (p. 14) and that Heller "was asked by the committee to return for cross-examination but did not do so." (p. 15). What the court failed to consider is that the committee gave the plaintiff 3½ days in which to put on her case in March 1990. Dr. Heller appeared on one of those days, testified until 5:00 p.m. and was willing to continue into the evening, but the committee

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[8] The committee was aware that the occurrence reports were undated, unsigned and not contemporaneously made because they were introduced in evidence at the hearing; Vakharia identified the inconsistencies with respect to specific cases (DK#503, Ex. 41 A & B) and the scope and specificity of the ASA review (DK#572, p. 323-328) at the hearing.

decided to adjourn. Thereafter the committee gave him two days on which he could appear, but because of his own work, he could not return on those days (DK#497, p. 33). The committee then did not give any further dates and adjourned the hearing.

Plaintiff suggests that this effort by a non-lawyer in her own defense cannot outweigh the obdurate refusal of the committee to allow evidence of disparate treatment even when they were notified that it existed.

The court sets down Dr. Loeber's remarks about Dr. Chookaszian as "an all American blond with a funny last name" as being a "stray remark" (p. 10, Fn. 7) when it was made at the time that her addition to the staff was creating what was later termed by the hospital as a "surplus of anesthesiologists". It speaks of a "performance audit"[9] by Loeber[10] of Vakharia in March 1987 (p. 2) in the absence of the evidence that the hospital had already made an offer to Dr. Howard Konowitz to join the already overcrowded staff (SA2, ¶92). It does not note that while Dr. Loeber testified that she had incident reports in March 1987 (DK#572, p. 1022-24), on April 15, 1987, Dr. Alvin Somberg, Q.A. Director, wrote a memo to Loeber stating, "We have never received a single occurrence report since you began as Chairman of Anesthesia." Dr.

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[9] Vakharia disputed this characterization (SSA2, ¶79).

[10] Loeber's secret contract with SCH was never in force (SSA1, ¶70) and Vakharia continued to be directly requested to do cases; Vakharia applied for the position of Director in 1984 (SA5, ¶ 51) and again for Chairman in 1989 (SA20); Vakharia received health and other benefits from SCH (DK#548, Affidavit ¶ 6 & 17).

Loeber did not request a response until August 1987 (SA2, ¶111, 121). The court did not consider the testimony of Diedre Porter Stinson, operating room manager, not only that Nurse Filipkowski searched the records on Vakharia's case for use in "Anesthesia Wars," but also that Dr. Loeber told her that herself, Konowitz, Chookhaszian and Myint were going to get the cases and that "We will keep Dr. Chang because she is nice," implying that the others were going to go. (SA 16, ¶17-19). The court finds that Dr. Vakharia went "on part-time rotation" (p. 3) and did not consider that the "part-time" nature of her work arose out of the size of the staff which now included Drs. Chookhaszian and Konowitz. (SA2, ¶129).

The court noted that in January 1988, Loeber introduced a new criteria for assignment of anesthesiologists and "board certification was to be the benchmark for senior status" (p. 3) but failed to consider is that under the by-laws Dr. Loeber had no authority to make such a classification, that being a matter to be determined by the credentials committee (SSA2, ¶56), as the ASA itself noted. Two of the favored group were not board certified while Vakharia was. The court did not accord the plaintiff the inference of discrimination which arises when a procedure is adopted and then dropped when it produces a nondiscriminatory result. The second classification system was premised on the position that the minority physicians were the least preferred by the surgeons. The court notes that Loeber testified that in March 1988, she conducted a poll of the preference of 35 of the 71 surgeons and Vakharia was least preferred (p. 3). The court did not consider that Dr. Loeber and the hospital could not identify who the surgeons were or produce the results

of the poll! A failure to produce evidence gives rise to an inference that had it been produced, it would have been favorable to the requesting party, *Partington* v. *Broyhill Furniture Industries, Inc.*, 999 F.2d 269, 272 (7th Cir. 1993). Later when more doctors requested Dr. Vakharia than others, i.e., that she was popular with the surgeons, the court notes, p. 4, fn. 1, "For example, Vakharia began soliciting work primarily from foreign medical graduates." Vakharia's practice profile shows she was doing cases for almost all the surgeons in the department, USMGs and FMGs (SA27).

While the court states that "on the basis of a review conducted by the Quality Assurance Department, Loeber identified 66 cases in which Vakharia had demonstrated inadequate job performance, (p. 3)" Vakharia's evidence is that there was no such review, that Dr. Loeber conducted her own "review" in retaliation for Dr. Vakharia's claim of discrimination in June 1988 to the Medical Executive Committee (SA2, ¶ 165-219). This "review" only occurred after Vakharia complained of discrimination, yet plaintiff was not accorded the inference of retaliation described in *Daniels* v. *Pipefitters' Ass'n Local No. 597*, 945 F.2d 906 (7th Cir. 1991), *cert den.* 503 U.S. 951 (1992) by the court.

The court also labels Dr. McCormick's threat to Dr. Vakharia that she should resign in order to avoid airing "dirty laundry" as a "stray remark" even though it made in the context of blackmail by McCormick who was telling the minority physicians that if they left they would get favorable letters and no report to the Illinois Disciplinary Board while if they fought, they would get just

the opposite. Under Illinois law, any involuntary reduction in privileges must be reported to the Disciplinary Board (Illinois Medical Practice Act, III. Rev. Stat. Ch. 111, §4400-23 (1998)) and obviously it would be a terrible lie, a breach of ethics, to falsely advise another hospital of a physician's incompetence. After supposedly finding the work of the other two Asian American women to be substandard, the hospital wrote glowing letters about both of them to other hospitals (SA 17, 18).[11]

The court notes that in November 1988, the ASA was "brought in" (p. 4) but only after the hospital was able to formulate its request as being for something other than peer review (SA2, ¶ 262-6). While the court concludes (p. 4, fn 1) that because Vakharia "initiated her own review of the records of other anesthesiologists,[12] Loeber responded by restricting Vakharia's access to Loeber's office where some emergency supplies were housed." The court fails to note that the records were housed six floors below in the medical records department which always has high security.

This court credits the ASA report as "based on a thorough review by independent, qualified professionals on whose credentials the committee was entitled to rely." (p. 16). The court fails to consider the fact that the visit of Wender and Blancato to the hospital was not done as peer review (DK#572, p. 324) nor was the report itself (DK#572, p. 410, 411), yet the ASA not only allowed the

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[11] Judge Wood noted this contradiction during the oral argument.

[12] Vakharia denied reviewing records of other anesthesiologists.

report to be used as "peer review," it prevented a number of the most prominent anesthesiologists in the country from testifying before the ad hoc committee (SA31; DK#503, Ex. 43E). Appellant suggests that a reasonable person could believe that the ASA report and the work of Wender and Blancato would not stand scrutiny by persons whose credentials far outshone those of Drs. Wender and Blancato.

Not only did Wender and Blancato not conduct a peer review in accordance with ASA guidelines as the ASA correspondence itself indicates, as Wender testified they relied upon the truth of statements made to them by the hospital administration and accepted in particular the hospital's biased selections of the cases rather than the appropriate random selection (DK#497, Ex. 2; DK#572, p. 1128-1398). While as this court has noted, "the report identified general problems intubating patients and cited inadequate management of complex cases of cases (p. 4-5), "But the court did not note that with two exceptions the report did not designate specific cases (SA2, ¶ 412-20). This omission takes on more significance when one considers that as originally written by Wender, the report cited no cases, while in the final draft the few cases mentioned were included although neither Wender not Blancato had anything to do with the report after the first draft (SA2, ¶ 410, 411). The report offers no comparative analysis although it recites the hospital's position that the "seniors" did more sophisticated work, even though the operative reports show otherwise (DK#497). While this court stated that "Vakharia has not raised any evidence to show that the ASA report was in any way tainted," yet both Drs. Heller and O'Brien questioned Dr. Wender's

veracity in their testimony before the panel; Heller "became very suspicious because I don't know how he could glean from those records and arrive at those opinions when you just look at the charts and the medical records" (DK#572, p. 2524-25); he noted the "inconsistencies of Dr. Wender" (DK#572, p. 2556); that he "felt that the peculiar statements that he made were prejudicial in nature and not substantiated in the literature or in the cases that I witnessed" (DK#572, p. 2551). He testified that Wender's testimony would not have gotten past a panel of anesthesiologists (DK#572, p. 2530). He believed the ASA report was "prejudiced" (DK#572, p. 2575-77). Dr. O'Brien testified that Dr. Wender's testimony had been given as if he had not read the charts but simply relied on the face sheets or case summaries supplied by SCH (DK#572, p. 2677-78, 2718), she had made "several dogmatic statements that are basically not true," another of which had "no basis in reality" and yet another which "had no basis in fact." (DK#572, p. 2628, 2641, 2647).

V.

THE VIOLATIONS OF PROCEDURE WERE THE MEANS BY WHICH DISCRIMINATION WAS ACCOMPLISHED

The court concluded, p. 17 "But we can see nothing in the record that would suggests that Vakharia was denied the procedural safeguards generally associated with an internal review process."[13] The bylaws required Dr. Loeber to voice any concerns she had regarding Dr.

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[13] Plaintiff's Motion for Partial Summary Judgment details the alleged violations of the bylaws (SSA2, ¶ 49-80).

Vakharia's competence to the credentials committee, yet every year she recommended that Dr. Vakharia's prvileges be renewed (SSA2, ¶54). The ASA report itself was to be given to the Credentials Committee itself yet Dr. McCormick kept it out of their hands and used it as a basis for suspending the minority physicians (SSA2, ¶59). The court itself noted that the *ad hoc* committee membership was "appointed by the hospital administration" (p. 5), which is also a violation of the bylaws (SSA2, ¶65). Moreover the criteria the administration used was the ability of potential members to serve as a "grand jury" and their ability to forestall " 'big dollar' litigation that is forming." (SA 14). All of the Asians and the one woman proposed by the medical staff president were discarded as members of the committee (DK#587, p. 39-43; DK#583, p. 19). The chairman who was chosen had already expressed a dislike of Dr. Vakharia. (SA2, ¶ 490; DK#584, p. 39). Few cases of the plaintiff involved any complications, and of those that did, this physician's care was potentially implicated as was that of another committee member. The hearing officer for the panel was a friend of the law firm representing the hospital, and that law firm represented not only the hospital but the *ad hoc* committee itself (DK#584, p. 59, Ex. 9). In order to name this hearing officer, the committee by-passed a former Illinois Supreme Court judge, other distinguished former jurists, and a physician-lawyer on the staff of SCH as well as Chief of Surgery at Mount Sinai Hospital. The fee statement of the hearing officer shows *ex parte* conferences with the attorneys for the hospital, including when he was preparing the final report for the committee (DK#584, Ex. 10, SCF 4285, 4288, 4291, 4292, 4298, 4300).

Under these circumstances, the unfairness of the proceeding is presumed, *Walker* v. *City of Berkeley*, 951 F.2d 182, 184 (9th Cir. 1991); *In Re Scattered Corporation*, 1998 SEC Lexis 24214 (1998) pp. 14-15) (SSA 4).

CORRECTIONS

The court has cited Appellant's 2nd Supplemental Appendix at pages 4, 6 including fns. 4 and 5 of its opinion. The reference is to Appellees' Supplemental Appendix. On page 7, the court also states that the defendants moved for summary judgment on all counts. The defendants moved for summary judgment on all counts except the anti-trust count. The trial court treated a previously filed motion to dismiss as a motion for summary judgment.

CONCLUSION

In light of the foregoing, the Plaintiff-Appellant Usha Vakharia, M.D., respectfully prays this court to grant a rehearing and that this court reverse the judgment of the district court and enter judgment on Counts I-V and VII for Plaintiff and remand this case on all counts as above specified and grant such other or further relief as the Court in its discretion shall deem appropriate.

Respectfully submitted,
USHA VAKHARIA, M.D.

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No. 99-1481

IN THE

Supreme Court of the United States

USHA VAKHARIA, M.D.,

Petitioner,

v.

SWEDISH COVENANT HOSPITAL,
AMERICAN SOCIETY OF ANESTHESIOLOGISTS, *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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QUESTIONS PRESENTED

I. In this case where a hospital peer review committee terminated plaintiff's hospital staff privileges based on unrebutted, unbiased and credible evidence presented during a nineteen-day hearing that plaintiff's care was substandard and a threat to patients, did the Court of Appeals and the District Court correctly rule that plaintiff failed to present sufficient evidence of pretext to survive defendants' motion for summary judgment on plaintiff's discrimination claims under the well-established burden shifting approach set forth in *McDonnell-Douglas Corp. v. Green*, 411 U.S. 792 (1973)?

II. Whether the Court of Appeals and the District Court abused their discretion by denying plaintiff additional discovery when the case was three years old, voluminous discovery had already been permitted, and dispositive motions were fully briefed?

III. Whether the Court of Appeals and the District Court abused their discretion in denying plaintiff leave to file a proposed fourth amended complaint seeking to add expansive state-law claims after voluminous discovery had been taken in the three-year old case, and while dispositive motions were pending?

IV. Whether the Court of Appeals and the District Court abused their discretion in disregarding portions of plaintiff's 106 page, 555 paragraph Local Rule 12M statement of uncontested facts as replete with hearsay, self-interested conclusions and unsupported fact assertions?

V. Whether the Court of Appeals and the District Court employed the correct standard in determining that plaintiff lacked standing to assert Title VII and ADEA claims because she was an independent contractor, not an employee or applicant for employment with the Hospital?

CORPORATE DISCLOSURE STATEMENT

Respondent Swedish Covenant Hospital furnishes the following information in compliance with Supreme Court Rule 29.6:

(1) Swedish Covenant Hospital is a Section 501(c)(3) corporation. Its sole corporate member is Covenant Ministries of Benevolence.

(2) There is no parent or publicly held company owning more than 10% of the corporation's stock.

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STATEMENT OF THE CASE[1]

Swedish Covenant Hospital (the "Hospital") is a not-for-profit Chicago hospital affiliated with The Evangelical Covenant Church. At all pertinent times the Hospital staff was equally divided between American and foreign educated physicians. In 1984, the Hospital's leadership made a commitment to improve the Hospital's anesthesia care and expand the staff. (McCormick Aff. ¶¶ 20-21) The Hospital recruited new anesthesiology leadership, and in 1985 Nancy Loeber, M.D. joined the Hospital as head of anesthesiology within the Department of Surgery. (12M ¶ 66; McCormick Aff. ¶ 22; Loeber Aff. ¶ 2) Dr. Loeber was well-credentialed for the position. She was an instructor at Harvard Medical School and Director of Education and Residency Evaluation for the Department of Anesthesia Rotating Residents at Children's Hospital in Boston. During her professional training, she earned fellowships in both cardiovascular anesthesia and pediatric anesthesia. (Loeber Aff. ¶ 2; Def. Ex. 3)

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1. Defendants' Local Rule 12M Statement ("12M ¶¶ ___") and the supporting affidavits of James McCormick ("McCormick Aff. ¶ ___"), Nancy Loeber ("Loeber Aff ¶ ___"), Alan Rogin (Rogin Aff. ¶ ___), and Ronald Wender ("Wender Aff. ¶ ___"), Docket Number ("DK ___") 532, are reproduced in Appellees' Supplemental Appendix ("Supp. App."), submitted to the Court of Appeals, as Tabs 1-5, respectively. Defendants' Exhibits to Their Motion for Partial Summary Judgment ("Def. Ex. ___") are at DK 572-1 to 572-7. Def. Ex. 42, ASA on-site consultation program for SCH ("ASA Report"), is reproduced at Supp. App. Tab 6. Def. Ex. 68, Report of Ad Hoc Peer Review Committee ("Comm. Report"), is reproduced at Supp. App. 7. Def. Exs. 81-89, the Ad Hoc Hearing Transcript, is cited as "Trans." Plaintiff's Local Rule 12N Statement (12N, ¶ ___") is DK 539. "S__" and SA__" refer to Appellant's Appendix and Supplemental Appendix, submitted to the Court of Appeals.

In January 1986, a separate Department of Anesthesiology was formed and Dr. Loeber was appointed chair. Dr. Loeber had responsibility for all case assignment and staffing decisions. (12M ¶ 70; McCormick Aff. ¶ 24; Loeber Aff. ¶ 3; Def. Ex. 4) She also developed modern performance criteria for all types of anesthesia and a quality assurance system requiring all anesthesiology complications to be reported to her. (12M ¶¶ 73-76; Loeber Aff. ¶ 4; Def. Ex. 6) As part of that system, she and the quality assurance staff implemented a generic screening program for identifying problem cases through quality indicators in accordance with industry standards. (12M ¶ 77; Loeber Aff. ¶ 4; Def. Ex. 7; Loeber Dep. at 693-95)

Around March 1987, Dr. Loeber conducted a performance audit on Dr. Vakharia. (12M ¶ 79; McCormick Aff. ¶ 27; Loeber Aff. ¶ 6; Def. Ex. 8; Loeber Dep. at 472-73, 476-78, 709) The audit uncovered 13 cases in which Dr. Vakharia had difficulty intubating patients or failed to properly supervise unstable patients in the recovery room. (12M ¶ 80; Loeber Aff. ¶ 6; Def. Ex. 8) Eleven of the 13 incidents had occurred within one year of the audit. (Def. Ex. 8)

On March 27, 1987, Dr. Loeber wrote to Dr. Vakharia, asking her to explain the 13 cases. (Loeber Aff. ¶ 7; Def. Ex. 8; Loeber Dep. at 476-78, 710; Vakharia Dep. (DK576) at 361-63, 365-66) Dr. Vakharia responded much later, on September 3, 1987, by denying that the cases reflected problems with her care and blaming the reports on bias on the part of a nurse anesthetist. (12M ¶ 85-86; Loeber Aff. ¶ 8; Def. Ex. 10) Dr. Loeber considered Dr. Vakharia's answers unsatisfactory. (*Id.*)

In September 1987, Dr. Vakharia requested and received from Dr. Loeber permission to go on a part-time rotation. (12M ¶¶ 87-88, 91-92; Loeber Aff. ¶ 9-10; Def. Exs. 11, 77, 78) On September 28, 1987, Dr. Vakharia wrote Dr. Loeber, thanking her for that permission. (12M ¶ 89; Def. Ex. 77) Dr. Vakharia later testified that she was grateful because she could spend more time with her family. (Vakharia. Dep. at 430-31, 463-69)

In January 1988, Dr. Loeber adopted new case assignment criteria. The "senior" anesthesiologists would receive more sophisticated or high-risk anesthesiology cases, and the "junior" anesthesiologists would receive less complicated cases, until they demonstrated competence in high-risk cases. (12M ¶ 94-95; McCormick Aff. ¶ 35; Loeber Aff. ¶ 11; Trans. at 1667-70, 1803-1804; Def. Ex. 15.) The new assignment guidelines did not affect any physician's staff privileges. (12M ¶ 97; Loeber Aff. ¶ 12; Def. Ex. 15.) Of the three anesthesiologists Dr. Loeber designated "senior", one was a woman and one was an Asian-born and educated male. (SA2 ¶ 146; 12M ¶ 5)

In June 1988, Dr. Vakharia asked that she be restored to full-time status as a senior anesthesiologist. (12M ¶ 102; Loeber Aff. ¶ 14) Dr. Loeber denied the request, explaining that the caseload would not support another full-time anesthesiologist at the junior or senior level, and Dr. Vakharia had not shown sufficient proficiency in more complex cases. (12M ¶¶ 103-104; McCormick Aff. ¶ 34; Loeber Aff. ¶ 14; Borenstein Dep. (DK582) at 105-13) When Dr. Vakharia challenged the decision, Dr. Loeber asked the Quality Assurance Department to compile all occurrence reports involving all Department members. (12M ¶ 105; Loeber Aff. ¶ 16; Loeber Dep. at 711-12; Borenstein Dep. at 105-13) From those reports and prior focus audits, Dr. Loeber

identified 66 cases in which Vakharia had demonstrated inadequate patient care or inadequate monitoring and documentation. (12M ¶ 106; McCormick Aff. ¶ 34; Loeber Aff. ¶ 16; Loeber Dep. at 711-12; Borenstein Dep. at 112-17) Of those 66 cases, all but a few had occurred during Dr. Loeber's tenure as chair of anesthesiology. (12M ¶ 107) Dr. Loeber used objective peer review criteria. (12M ¶ 108; Loeber Aff. ¶ 17; Def. Ex. 79)

On June 7, 1988, Dr. Vakharia asked the Hospital's Medical Executive Committee ("MEC") to restore her to full-time status. (12M ¶ 109; Def. Ex. 12) Dr. Demetrius Trakas, the medical staff president, appointed a task force to review Dr. Vakharia's request. (12M ¶¶ 113-114; Def. Ex. 13; Trakas Dep. at 9-10, 14, 86-87; Vakharia Dep. at 574-77, 586-88, 597-99) The task force recommended that the MEC defer to Dr. Loeber's judgment and affirm her decision to deny Dr. Vakharia's request to return to full-time status. (12M ¶ 117-118; McCormick Aff. ¶ 37; Loeber Aff. ¶ 19; Def. Ex. 17) The task force determined that Dr. Loeber, as chair, was best qualified to assign cases and to evaluate the skills of the anesthesiologists. (*Id.*) The MEC adopted that recommendation. (12M ¶ 119; McCormick Aff. ¶ 38; Loeber Aff. ¶ 20; Trakas Dep. Ex. 18; Vakharia Dep. at 599.) It took no position on quality of care issues, but voted to retain an anesthesia consultant to review the department. (12M ¶ 120; McCormick Aff. ¶¶ 37-38; Loeber Aff. ¶ 20; Trakas Dep. at 139-40; Trakas Dep. Ex. 18)

The Hospital retained the American Society of Anesthesiologists ("ASA"). The ASA is an independent association of anesthesiologists that conducts on-site audits of anesthesia care at hospitals through its "On Site Consultation Program." The program's aim is to provide a

"careful, unbiased and objective means" of evaluating the competence of anesthesiologists. (12M ¶ 133; Def. Ex. 27; Blancato Dep. (DK579) Ex. 7) Dr. Vakharia agreed to a review by the ASA. (12M ¶ 135; McCormick Aff. ¶ 46; Loeber Aff. ¶ 23; Def. Ex. 19)

In November 1988, Dr. Trakas wrote the ASA asking that it review the Anesthesiology Department and make recommendations on three issues: (i) whether there was an anesthesiologist surplus; (ii) whether there were quality of care issues with specific anesthesiologists; and (iii) the department's structure. (12M ¶ 136; Def. Ex. 28) The ASA accepted, assigning Drs. Ronald Wender and Louis Blancato to the ASA on-site team. (12M ¶¶ 137-38; Def. Exs. 34, 31) Dr. Wender was co-chair of the anesthesiology department at Cedar-Sinai Medical Center in Los Angeles. (12M ¶ 139; Def. Ex. 32) Dr. Blancato was a former president of the ASA. (12M ¶ 140; Def. Ex. 33) The Hospital played no role in selecting either reviewer, and neither reviewer knew Dr. Loeber or Dr. Vakharia. (12M ¶¶ 141-43; McCormick Aff. ¶ 51; Loeber Aff. ¶ 26; Blancato Dep. at 69, 234)

In advance of the site visit, Dr. Wender asked the Hospital to send several items of information including: (i) randomly selected charts on any anesthesiologist who had major complications; and (ii) charts on any major complication. (12M ¶ 146; Def. Ex. 37; Wender Dep. (DK580) at 178-82) Dr. Loeber assisted in selecting material to be sent to Dr. Wender. (12M ¶ 147; Loeber Aff. ¶ 25) Of the 66 Vakharia cases she had reviewed, she identified 17 as reflecting "major complications." (*Id.*) In March and April 1989, the Hospital's Director of Legal Affairs, Judith Borenstein, sent Dr. Wender the information he requested. (12M ¶¶ 150-52; Def. Exs. 38, 39, 41; Wender Dep. Exs. 11,

12, 13, 14; Wender Dep. at 231-33; Borenstein Dep. Ex. 6.) In all, the Hospital sent the ASA more than 200 cases involving all anesthesiologists, including 43 cases in which Vakharia experienced major complications and 24 cases selected randomly. (12M ¶ 153, McCormick Aff. ¶ 59; Borenstein Dep. Ex. 6) Ms. Borenstein also sent 18 cases of other anesthesiologists at Dr. Vakharia's request. (12M ¶ 152; Def. Ex. 41) Dr. Vakharia was shown all of her charts sent to the ASA. (12M ¶ 154; McCormick Aff. ¶ 60; Trans at 936-37, 1139-40, 2887-88) Also, Dr. Vakharia was permitted to submit 220 pages of material to Dr. Wender, some of which allegedly concerned complications involving other anesthesiologists. (12M ¶ 156; Vakharia Dep. at 772-77, 839-42, 856-59)

Dr. Wender spent two days at the Hospital and Dr. Blancato spent a day and a half there, reviewing documents and interviewing staff. (12M ¶ 157) Dr. Vakharia was interviewed three different times. (12M ¶ 158) Dr. Wender personally observed Vakharia in the operating room. (ASA Report at 5) Drs. Wender and Blancato reviewed approximately equal numbers of randomly-selected records for each anesthesiologist. (12M ¶¶ 160-61; Trans at 191-92, 195-97, 270-77, 315-21, 1288, 1321) The ASA submitted its independent report on the Anesthesiology Department in June 1989. (12M ¶ 163; ASA Report) The Hospital did not communicate with Dr. Wender, Dr. Blancato or anyone at the ASA while the report was prepared. (Vakharia Dep. at 863-65)

With respect to Dr. Vakharia, the ASA Report documented serious deficiencies in her care and concluded that her medical staff privileges should not be renewed. The report made similar recommendations with respect to the two other anesthesiologists who had been restricted to "junior" status by Loeber. (ASA Report at 15; Wender Aff. ¶¶ 3-6)

The report stated, in pertinent part:

> The consultants reviewed incident reports and records involving patients of all anesthesiologists in the department. There were some very serious complications attributable to substandard care delivered by Drs. Vakharia, [ ] and [ ]. These complications were indicative of a poor quality of anesthesia care, rather than a complication which one would expect as a natural result of the type of anesthesia and/or surgery involved.
>
> Anesthetic records indicate that Dr. Vakharia and Dr. [ ] have far more trouble intubating patients than does Dr. [ ] or other members of the Department. There were multiple cases involving difficult airway management and traumatic intubations. One such case of Dr. Vakharia involved esophageal perforation, pneumothorax, and extensive subcutaneous emphysema.

* * *

The most consistent and most damaging problem area for the three anesthesiologists was in the area of management of ASA Class III and IV patients. Where it was obvious that significant invasive monitoring was necessary on this category of patients (severe congestive failure, cardiac disease, etc.), this generally was either not done or was poorly accomplished.

* * *

> In Class III and IV patients anesthetized by Dr. Vakharia, there was a consistent problem with preoperative evaluation and with fluid management. . . . While major catastrophic events did not occur in many of these cases, this is certainly consistent with the general impression gained by the consultants that she "dumped" patients in the recovery room.

(*Id.* at 11-12)

Upon receiving the ASA Report, Dr. Trakas, the President of the Medical Staff, and Dr. James McCormick, the Hospital President, agreed that the staff privileges of Dr. Vakharia and the other two anesthesiologists should be summarily suspended under the Bylaws. (12M ¶ 171; McCormick Aff. ¶ 65) Drs. Trakas and McCormick agreed that each physician should first have an opportunity to take a leave of absence to consider whether to resign or accept summary suspension. (12M ¶ 172; McCormick Aff. ¶ 65) Dr. Vakharia elected not to resign, and on July 31, 1989, her privileges were summarily suspended by Dr. McCormick, with Dr. Trakas's concurrence. (12M ¶ 174-175; McCormick Aff. ¶ 68; Def. Ex. 46) On August 24, 1989, Dr. Vakharia formally requested a hearing under the Bylaws. (12M ¶ 182) On September 1, 1989, the Hospital sent Dr. Vakharia a notice of hearing that itemized the reasons for the summary suspension. (12M ¶¶ 183-84)

The hearing committee members were appointed by Dr. Trakas pursuant to the Bylaws. (12M ¶ 217) The committee consisted of Drs. Garry Melnick, Miguel Oviedo, Alan Rogin, Jerrold Shapiro and Joseph D'Silva. (Comm. Report) None of the aforementioned individuals was an

anesthesiologist or competed with Dr. Vakharia. (12M ¶ 188) In fact, Dr. Oviedo had previously written a letter supporting Dr. Vakharia. (12M ¶ 189)

Before the hearings began, the committee asked the parties to submit written positions on the proper scope of the hearing by October 16, 1989. (12M ¶ 194; Rogin Aff. ¶ 4; Shapiro Dep. (DK585) at 244-48, 267; Oviedo Dep. (DK586) at 105-106; Def. Exs. 52-53; Rogin Dep. (DK584) at 87-93, 108-10) The Hospital complied, but Dr. Vakharia and her counsel did not. (12M ¶¶196-97; Rogin Aff. ¶ 5; Shapiro Dep. at 279) On October 19, the committee voted to limit the scope of the hearing to the issue of whether the summary suspension was proper. (12M ¶ 198; Def. Ex. 54) It also voted to allow attorneys to attend the hearing in an advisory capacity only. (12M ¶ 199; Def. Ex. 54) The committee chose as its hearing officer Michael Hannafan, an independent attorney nominated by the Hospital. (12M ¶ 211)

The hearings began on November 3, 1989. The committee held 19 days of hearings. It compiled a 3,130-page record and received 38 exhibits from the Hospital and more than 200 from Dr. Vakharia. (12M ¶¶ 218-19) The Hospital presented four witnesses, and Dr. Vakharia presented 21, including two purported experts. (12M ¶¶ 220-21; Trans. at 1-3130) Dr. Vakharia refused to testify on her own behalf. The Hospital thus required her to submit to cross-examination, as the Bylaws provided. (12M ¶ 221; McCormick Aff. ¶ 76; Rogin Aff. ¶ 15) Janis Anderson, the Hospital's manager of quality assurance/risk management, testified on the process for selecting case records submitted to the ASA review team. (12M ¶¶ 222-23; Trans. at 31-74, 67-68; Def. Ex. 37)

Dr. Wender then testified that: (i) he and Dr. Blancato reviewed the entire Anesthesiology Department; (ii) he and Dr. Blancato received and reviewed all information in the medical charts, not just the face sheets prepared by Dr. Loeber; (iii) he personally discussed each of Dr. Vakharia's cases with her at length, but was dissatisfied with her answers; (iv) he and Dr. Blancato received and reviewed more than 200 pages of materials from Dr. Vakharia; and (v) he and Dr. Blancato prepared the ASA report without any consultation by the Hospital. (12M ¶¶ 224-25; Trans. at 177-86, 184-97, 262-65, 270-77, 315-21) Dr. Wender testified that in many, but not all, cases Dr. Vakharia did not meet the national minimum standards of care. (12M ¶ 228-229; Trans. at 201-34, 311-13, 321-22, 348-50) The committee permitted one of Dr. Vakharia's attorneys to cross-examine Dr. Wender on the procedures used during the ASA review. (12M ¶ 226; Trans. at 236-277) Dr. Loeber then testified on each category of problems she had identified in Dr. Vakharia's care. She explained that Dr. Vakharia: (i) had difficulty intubating patients; (ii) inappropriately managed obstetrics patients, particularly high-risk patients; (iii) poorly handled ASA class III and IV (seriously ill) patients; (iv) performed poor airway management and over-narcotized; (v) poorly introduced regional anesthesia; and (vi) maintained improper and deficient documentation. (12M ¶ 234; Trans. at 567-850) Dr. Vakharia was permitted to cross-examine Dr. Loeber at length. (12M ¶ 235; Trans. at 979-1116)

During his initial testimony and on cross-examination by Dr. Heller, one of Dr. Vakharia's experts, Dr. Wender generally discussed the problems he had identified with Vakharia's care. (12M ¶ 236; Trans. at 310-20, 344.) Dr. Vakharia demanded that he return to be cross-examined

on the details of her cases. (12M ¶ 237; Trans. at 360) The committee asked that Dr. Wender return from Los Angeles for another day of more case-specific testimony. (12M ¶ 238; Trans. at 360-65) Dr. Wender agreed and spent over 30 hours reviewing Dr. Vakharia's cases. (12M ¶ 241; Trans. at 1154-64)

To assist Dr. Vakharia, the hearing committee again told Dr. Vakharia she could have her expert cross-examine Dr. Wender on the cases. (12M ¶ 239; Trans. at 1125) She declined and she refused to address her cases at all. Instead, she spent six hours examining Dr. Wender on procedural details that had been covered previously. (12M ¶¶ 242-43; Rogin Aff. ¶ 20; Trans. at 1152-1375) The hearing committee repeatedly asked Dr. Vakharia to concentrate on cases, but she refused. (12M ¶ 244; Rogin Aff. ¶ 20; Trans. at 1176-77, 1200-1203, 1218, 1273-74, 1280, 1290, 1352)

Dr. Floyd Heller, one of Dr. Vakharia's purported experts at the hearing later submitted an affidavit in support of her summary judgment motion. (SA 8) In that affidavit, filed five years after the peer review process had ended, Dr. Heller took exception with many of Dr. Loeber's criticisms of Dr. Vakharia's care. However, Dr. Heller questioned only a handful of the points raised by Dr. Loeber during the actual peer review hearing and did not return to the hearing to cross-examine Dr. Wender on the details of Dr. Vakharia's cases. (Trans. at 2503-2584, 2759-60; 12M ¶¶ 261-62; Rogin Aff. ¶ 25) Dr. Heller's direct testimony at the hearing was not case-specific. (12M ¶ 251; Rogin Aff. ¶ 25; Trans. at 2503-2584) He generally defended Dr. Vakharia, but conceded for example that her use of a 22-gauge needle in an epidural procedure fell below the standard of care, and also testified that poor preoperative charting and failure to conduct

physical examinations was not proper anesthesia practice. (12M ¶¶ 253-54; Trans. at 2537, 2564-67) Dr. Heller left before the Hospital could begin cross-examination and declined to return. (12M ¶ 259; Rogin Aff. ¶ 25) Dr. Vakharia's other purported expert at the hearing, Dr. O'Brien, testified regarding some of the cases reviewed by the ASA. (12M ¶ 255, Trans. at 2597-2760) Like Dr. Heller, Dr. O'Brien had to leave after less than an hour of cross-examination and did not return for additional testimony. (12M ¶ 260; Trans. at 2725-60) Dr. Vakharia's other witnesses were not experts and generally had not reviewed the charts.

After the hearing, the committee issued a six-page opinion recommending that the summary suspension be upheld. The opinion found:

(i) Dr. Wender was "extremely well qualified, neutral and objective";

(ii) The committee was troubled by the fact that Dr. Vakharia "steadfastly avoided asking Dr. Wender questions about her several cases he specifically examined";

(iii) Dr. Vakharia appeared to be incapable of accepting criticism and incapable or unwilling to address noted deficiencies in her practice;

(iv) The committee "was troubled by Dr. Vakharia's unfounded, continual and, at times, hysterical charges of prejudice and other evil motives in response to criticism";

(v) "None of Dr. Vakharia's witnesses effectively rebutted the compelling testimony of Dr. Wender or Dr. Loeber."

(Comm. Report)

The MEC adopted the committee's recommendation on May 9, 1990. (Def. Ex. 69) On May 16, Vakharia exercised her right to have the Hospital Board review the decision. (Def. Ex. 70) The Hospital Board appointed a six-member appellate committee, none of whom were involved in prior proceedings. (12M ¶ 268; McCormick Aff. ¶ 84) Dr. Vakharia and the Hospital submitted written position statements. (12M ¶¶ 269-70; Def. Exs. 72, 73)

On September 7, 1990, the appellate committee issued a 21-page opinion addressing each of Dr. Vakharia's 25 points on appeal and recommended that the Board adopt the MEC decision. (12M ¶ 274-275; Def. Ex. 74.) On September 13, 1990, the Board unanimously affirmed the permanent suspension of Dr. Vakharia. (12M ¶ 276-77) The Hospital President, Dr. McCormick, did not participate in the deliberations. (12M ¶ 278; McCormick Aff. ¶ 90)

REASONS FOR DENYING THE WRIT

A. This Court Should Deny The Writ On The First Question Presented Because The Court Of Appeals Applied The Correct Standard To The Undisputed Facts Of This Case And That Decision Is Not In Conflict With Other Circuits.

Dr. Vakharia's first question presented is based on the erroneous premise that the courts below evaluated the honesty of the peer review committee's decision to terminate Dr. Vakharia's staff privileges solely on the evidence adduced at the ad hoc hearing. (Pet. 15-18) The courts below did not take such a myopic approach but instead carefully reviewed the entire record, including Dr. Vakharia's unsupported accusations of bias, procedural irregularities and discriminatory animus, and correctly ruled that the decision of the peer review committee — the primary decision-maker in this case — was genuine rather than pretext for discrimination. As set forth more fully below, the first question presented is based on a misreading of the opinions and factual record below, and therefore, presents no important question of federal law that warrants this Court's review.

In an employment discrimination case, the plaintiff is required to show either direct or indirect evidence of discrimination. *McDonnell-Douglas Corp. v. Green*, 411 U.S. 792, 802 (1973); *Bruno v. Crown Point*, 950 F.2d 355, 261 (7th Cir. 1991), *cert. denied*, 505 U.S. 1207 (1992). Since Dr. Vakharia relied on indirect evidence, the Court of Appeals properly applied "the familiar burden-shifting method established by *McDonnell-Douglas* . . . and progeny." (Pet. App. 11-12) Under the *McDonnell-Douglas* approach, the plaintiff must establish a prima facie case of

employment discrimination. If the plaintiff establishes a prima facie case, then the employer must articulate a legitimate, non-discriminatory reason for its decision. If the employer does so, the burden shifts back to the plaintiff to prove that the employer's proffered reason was pretextual. *McDonnell-Douglas,* 411 U.S. at 801-04. The plaintiff bears the ultimate burden of demonstrating an impermissible motive or intent. *See St. Mary's Honor Center v. Hicks*, 509 U.S. 502, 506-07 (1993).

The parties framed Dr. Vakharia's discrimination claims in terms of pretext. (Pet. App. 13) Since the Hospital asserted that it terminated Dr. Vakharia's staff privileges because "her care was substandard and harmful to her patients," the Court of Appeals correctly determined that the issue was "whether the ad hoc peer review committee — the primary decision maker in this case — genuinely believed that the care [Dr. Vakharia] provided was inferior." (Pet. App. 13-14, 16) Dr. Vakharia had the burden on summary judgment to come forward with evidence to show the Hospital's explanation was not genuine or worthy of credence. (Pet. App. 14)

Stripped of hyperbole, Dr. Vakharia's Petition asks this Court to review the opinion below because she claims the Court of Appeals disregarded her alleged evidence of pretext. That alleged evidence consists of: (i) the peer review committee's decision to limit the scope of the peer review hearings to Dr. Vakharia's own quality of care, rather than her allegations of discrimination or the quality of care provided by other department anesthesiologists; and (ii) unsupported suggestions of bias and irregularities in the hearing process (and the prior ASA review). The Court of Appeals fully considered the record below — including her "evidence" — and correctly ruled that Dr. Vakharia "failed

to show that [the Hospital's] explanation for suspension of her privileges — that the quality of her care was substandard — was less than honest." (Pet. App. 19)

First, there is no evidence that the peer review committee excluded Dr. Vakharia's discrimination charges or prohibited comparative chart analysis to "immunize itself and its decisions from attack by a screen of plausible denial" as Dr. Vakharia suggests. (Pet. 17) The committee voted to limit the scope of the hearing to her quality of care only after it requested that the parties, including Dr. Vakharia, submit written positions on the proper scope of the hearing. The Hospital complied, but Dr. Vakharia and her counsel did not. (*See supra* at 9.) Indeed, the peer review committee had no obligation to review anybody other than Dr. Vakharia in the first place.

While Dr. Vakharia complains that she was denied the opportunity to compare her cases to the work of other anesthesiologists at the Hospital, nothing precluded Dr. Vakharia or her experts from reviewing any record of her choosing with Dr. Wender (or Dr. Loeber) and taking issue with him at the hearing on the adequacy of Dr. Vakharia's care in that specific case based on national or even community standards of care. Expert witnesses in medical malpractice cases are routinely asked to give an opinion on whether the defendant physician or hospital met the requisite standard of care without the type of chart by chart comparative analysis requested by Dr. Vakharia. Instead, as the Court of Appeals recognized, Dr. Vakharia and her expert sandbagged the Committee and the Hospital by refusing to address her cases at all. (Pet. App. 16-18)

The record fully supports the Court of Appeal's conclusion that neither Dr. Vakharia nor her experts addressed the "heart

of SCH's evidence, namely, the numerous specific cases." (Pet. App. 17) For example, when one of the Hospital's witnesses, Dr. Wender, returned from Los Angeles (at Dr. Vakharia's request) for another day of case-specific testimony, Dr. Vakharia declined the committee's invitation to have an expert cross-examine Dr. Wender and refused to address the cases at all. Instead, Dr. Vakharia wasted six hours, from about 2:00pm to 8:00pm, examining Dr. Wender on procedural issues that had been covered previously. The committee repeatedly asked her to concentrate on cases, but she refused. (*See supra* at 12-13) In sum, Dr. Vakharia's focus on "comparative" evidence is not important enough to warrant this Court's scrutiny because the mere fact that the peer review committee refused to allow such evidence does not alone create a genuine issue of fact undermining the honesty of the peer review committee's decision.

Second, further demonstrating that the Court of Appeals did not act with blinders on, it considered, and then correctly concluded that the Hospital granted Dr. Vakharia "all the procedural safeguards generally associated with an internal peer review process" and that Dr. Vakharia failed to "point to any direct evidence of bias." (Pet. App. 19-20) Dr. Vakharia suggests that certain unidentified surgeons on the peer review committee were biased because their quality of care was also at issue, but there is no admissible evidence to support that accusation. Notwithstanding years of scorched-earth discovery in the trial court, Dr. Vakharia never established any evidence of actual bias on the part of any member of the peer review committee or the committee's counsel, despite her repeated, unsupported suggestions to the contrary.

Dr. Vakharia makes a host of other factual misstatements in a final effort to show the process was tainted. For example, she claims that Dr. Loeber selected all of the ASA cases even though she submitted charts and other material to the ASA. She also claims she only had only four days to put on her case. In addition to the time allotted for her case, Dr. Vakharia had the opportunity to cross-examine the Hospital's witnesses, including an additional day with Dr. Wender. And her main expert, Dr. Heller, declined the committee's invitation to return for another day of testimony. (SA8 ¶ 33) Whereas Dr. Wender flew back from Los Angeles for another day of testimony, Dr. Heller, who practices in Chicago, admitted that he did not attempt to "rearrange [his] schedule or request any further dates." (SA8 ¶ 33)

Finally, demonstrating that the Court of Appeals did not confine its review to the events in the peer review proceeding, the Court considered Dr. Vakharia's charges of direct discrimination. For example, while Dr. Vakharia boldly refers to the "racist remarks" in her petition, the Court of Appeals correctly concluded that all of the remarks of Drs. Loeber and McCormick, "which are in the nature of stray remarks," did not constitute direct evidence of discrimination. (Op. at 10 n.7) Moreover, the comments of Dr. Loeber and Dr. McCormick are not even relevant to the pretext analysis because liability will not attach "when the ultimate decision is clearly made on an independent basis." *Willis v. Marion County Auditor's Office*, 118 F.3d 542, 547 (7th Cir. 1997).

The Court of Appeals' pretext analysis is not in conflict with *Bolt v. Halifax Hospital Medical Center*, 891 F.2d 810 (11th Cir.), *cert. denied*, 495 U.S. 924 (1990); *Miller v. Indiana Hospital*, 843 F.2d 139 (3d Cir. 1988), *cert. denied*, 488 U.S. 87 (1990); or *Brown v. Presbyterian Health Care Service*, 101 F.3d 1324 (10th Cir. 1996), *cert. denied*,

520 U.S. 1181 (1997). *Bolt*, *Miller* and *Brown* are antitrust cases, not employment discrimination cases, and, therefore, they cannot present a conflict among the Circuits in discrimination cases.[2] Because they are not discrimination cases, these courts, in considering the evidence, did not apply a pretext analysis. Moreover, unlike here, in *Bolt* and *Miller* the physicians had evidence of dishonesty, including direct financial conflicts of interest among members of the peer review committees. *Bolt*, 891 F.2d at 817; *Miller*, 843 F.2d at 144. *Brown* involved a claim of immunity under the Health Care Quality Improvement Act, 42 U.S.C. §§ 11111(a), 11112(a) (1994), an alternative basis to affirm summary judgment in this case.

B. The Writ Should Be Denied On The Second, Third And Fourth Questions Presented Because The Court Of Appeals Fully Considered The Issues and Properly Decided That The District Court Did Not Abuse Its Discretion.

In her second, third and fourth questions presented, Dr. Vakharia complains that she was improperly denied discovery, denied leave to amend her complaint and that the Court of Appeals failed to consider her conclusory 12M statement. The Court of Appeals fully considered each issue and correctly decided that the District Court did not abuse its discretion. None of these discretionary rulings raise any issues important enough to warrant exercise of this Court's supervisory authority.

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2. Dr. Vakharia's attempt to incorporate the arguments set forth in her Petition for Rehearing and Suggestions for Rehearing en Banc violates Rule 14.2 and, therefore, should not be considered.

The District Court acted within its discretion to deny Dr. Vakharia's discovery requests, particularly in view of the extensive discovery Dr. Vakharia had already requested. The court permitted Dr. Vakharia to depose all the affiants in support of the defendants' motion for summary judgment, the members of the peer review committee, as well as a host of other witnesses, including Drs. Wender and Blancato under Rule 56(f) of the Federal Rules of Civil Procedure. In three well-reasoned opinions, the district court concluded that Vakharia had already spent "an immense amount of time" with key witnesses on matters of "marginal relevancy," the depositions of Dr. Vacanti and Mr. Scott were largely irrelevant to the issues in this litigation" and "[t]he unsupported possibility that [ASA reports on other hospitals] might turn up something does not justify either the inevitable intrusion into confidential matters nor the resultant expansion of discovery." (Resp. App. 3a, 14a-15a; A69) Indeed, the District Court reviewed the ASA Report Dr. Vakharia obtained on another local hospital and found no support for her claims of an ASA program to eliminate foreign born anesthesiologists.

Similarly, the district court did not abuse its discretion in denying Dr. Vakharia's motion for leave to file a fourth amended complaint to add state law claims for defamation, false reporting and commercial disparagement on the grounds of undue delay and substantial prejudice to defendants. *See* Fed. R. Civ. P. 15. (A47-52) Judge Moran concluded that her proposed fourth amendment coming at the close of voluminous discovery, on the eve of rulings on dispositive motions, and nearly three years after the case was filed would unfairly prejudice the defendants and unduly complicate the case. Judge Moran noted that "this is a 1990 case that has been a pleading war." (A49) The proffered amendment would substantially increase the scope of the lawsuit at a time when

Dr. Vakharia "should not be multiplying theories but getting ready to deal with the merits of the case." (A50)

Dr. Vakharia suggests in her statement of the case that leave should have been granted because she did not learn the Hospital reported her termination to others until late in discovery, and the reports filed by the hospital exaggerated the circumstances of her termination. (Pet. 13-14, 18) There is no support in the record for Dr. Vakharia's statement that the report exaggerated the circumstances of her termination and therefore the District Court judge aptly commented that the new claims were "just more roads leading to Rome." (A49) In other words, if Vakharia succeeded in proving that she was terminated for discriminatory and anticompetitive reasons, false reports would be an element of her damages for discrimination and additional antitrust injury. If she failed to show pretext or anticompetitive motivation, then reporting her termination for substandard care was not defamatory, false or disparaging.

Finally, the District Court and Court of Appeals properly disregarded portions of Dr. Vakharia's 106 page, 566 paragraph 12M statement (her second statement of alleged factual assertions), her affidavit and other supporting documents because they are replete with hearsay, self-interested conclusions and unsupported fact assertions. Perhaps recognizing the correctness of the lower court's decision, Dr. Vakharia fails to even address the findings that her submissions lacked the requisite evidentiary foundation. Since review of the District Court's application of its own local rules will not affect other circuits, this question is particularly inappropriate for review. In sum, Dr. Vakharia has offered nothing to justify this Court's exercise of supervisory authority to review any of the foregoing discretionary decisions.

C. This Court Should Deny The Writ On The Fifth Question Presented Because Dr. Vakharia Did Not Raise The Issue Below And, In Any Event, The Court Of Appeals' Decision Is Consistent With This Court's Recent Opinions.

Dr. Vakharia asserts that it was wrong for the Court of Appeals to apply common law agency principles to determine whether she was an employee of the Hospital for purposes of Title VII and ADEA. The District Court, relying on *Alexander v. Rush North Shore Medical Center*, 101 F.3d 487 (7th Cir. 1996), *cert. denied*, 522 U.S. 811 (1997), held that Dr. Vakharia's Title VII and ADEA claims were barred because she was an independent contractor, not an employee or applicant for employment. In *Alexander,* the Court of Appeals applied a five factor common law test to determine that an anesthesiologist was not an employee under Title VII. Although the District Court invited Dr. Vakharia to address "any argument that the decision in *Alexander* is erroneous" to the Court of Appeals, she failed to do so. (Pet. App. 25) Instead of asking the Court of Appeals to overrule *Alexander*, Dr. Vakharia argued that "the high-degree of control [the Hospital] exercised over the minutiae of quality of care distinguishes this case from *Alexander*." (Br. at 17.) In other words, Dr. Vakharia merely argued that the Hospital in this case exercised sufficient control to deem her an employee under the Seventh Circuit's common law control test. In her Petition for Rehearing En Banc, Dr. Vakharia did not even mention her Title VII or ADEA claims. (Pet. App. 60-67) Since Dr. Vakharia did not urge the Court of Appeals to overrule *Alexander* or even argue that it was inconsistent with any statute or court decision, she waived her argument before this Court.

But even if Dr. Vakharia did not waive the issue, the Court of Appeals decision is in line with this Court's opinions in *Nationwide Mutual Ins. Co. v. Darden*, 503 U.S. 318 (1992) and *Community for Creative Non-Violence v. Reid*, 490 U.S. 730 (1989). In *Darden*, this Court adopted a similar common law control-oriented agency test to determine whether an individual is an employee under the Employee Retirement and Income Security Act ("ERISA"). This Court found that ERISA's definition of "employee" as "any individual employed by an employer" is "completely circular and explains nothing." *Id.* at 323. It further found nothing in the Act to suggest that construing the term employee "to incorporate traditional agency law principles would thwart the congressional design or lead to absurd results." *Id.* In rejecting the lower court's reliance on *NLRB v. Hearst Publications, Inc.*, 322 U.S. 111 (1994) (cited by Dr. Vakharia), this Court concluded that in *Reid* it had abandoned its prior emphasis on construing the term "employee" "in light of the mischief to be corrected and the end to be attained" under both the National Labor Relations Act and Social Security Act. *Id.* Since Title VII and ADEA define "employee" in the same circular manner as ERISA, the Court of Appeals' use of a common law test in this case was consistent with *Darden* and *Reid*.

The Court of Appeals' decision is plainly not in conflict with this Court's decision in *Robinson v. Shell Oil Co.*, 519 U.S. 337 (1996) as Dr. Vakharia suggests. (Pet. 22-23) In *Robinson*, this Court held that the anti-retaliation provision of Title VII applies to former employees. It did not address whether or not Title VII or ADEA applies to independent contractors. The Seventh Circuit Court of Appeals' decision in *Alexander* and in this case below followed this Court's precedent in *Darden* by utilizing a common law agency

definition to define employee. In *Darden*, this Court rejected the "economic realities" test set forth in *NLRB v. Hearst Publications* as "feeble precedent for unmooring the term [employee] from common law." *Darden*, 112 U.S. at 323. Moreover, this case is not the appropriate one to address the issue because even if Dr. Vakharia has standing, summary judgment on the merits would stand based on the Court of Appeals' decision in connection with her Section 1981 claims.

CONCLUSION

Wherefore, for the foregoing reasons, Respondents respectfully request that this Court deny the Petition for Writ of Certiorari.

Respectfully submitted,

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APPENDIX

APPENDIX A — MEMORANDUM AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION DATED SEPTEMBER 14, 1993

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS EASTERN DIVISION

No. 90 C 6548

USHA VAKHARIA, M.D.,

Plaintiff,

vs.

SWEDISH COVENANT HOSPITAL, et al.,

Defendants.

MEMORANDUM AND ORDER

A number of motions are now pending before this court and fully briefed. The first is a motion of The American Society of Anesthesiologists (ASA) for a protective order to prevent disclosure of ASA consultation reports at fifteen other hospitals in the survey of which Dr. Charles J. Vacanti and/or Dr. Louis S. Blancato participated. Plaintiff was not related to any of those hospitals. The motion is granted.

As this court has remarked on many occasions, this court has an obligation to manage discovery so as to keep it (or at least attempt to keep it) within reasonable bounds. The reports plaintiff seeks critique the operations of other

hospitals and the professional staffs of those hospitals. They may or may not be subject to a state privilege (we do not reach that), but the hospitals and physicians involved most certainly have a legitimate expectation of privacy, an expectation that the reports will not be disclosed whenever a physician at some other hospital sues that hospital on whatever claims may be advanced. The defeat of those expectations in those circumstances could well reduce the willingness to undergo such evaluations in the future. This court is also mindful that internal reviews of the quality of medical care are to be encouraged. That is the thrust of both federal and state law. Although any state privilege is not conclusive here, we do not believe that we should compel disclosure unless there are significant justifications for doing so. Further, as we earlier explained, we must be mindful of the possible expansion of discovery and proof into at best marginal areas should the reports of other hospitals become part of the factual mix here.

Plaintiff's initial justification is that the other reports might possibly contain language disclosing a discriminatory animus, such as code words. She refers to the report on another hospital of which she does have a copy, and she has attached a copy as an exhibit. She insists that she can delete the names of the physicians discussed therein and somehow still use the report to indicate a pattern and practice of minority physicians being singled out for criticism. In a later filing plaintiff claims that the reports may show racial comments, disclose a different methodology, verify that the ASA may be engaged in "ethnic cleansing," and lend support to the notion that Swedish Covenant Hospital selected ASA to make the report because it knew that it would prepare an unfair report. She uses as an example the report on the other

hospital. Her examples in that report are that in the description of the hospital the 34-page report notes that the hospital serves an area of 80% Hispanic population, has 50% Hispanic physicians and has all foreign medical graduate anesthesiologists, and that staff at the hospital commented that one or more anesthesiologists had some language problems (including the chairman). That is hardly grist for plaintiff's "code word" mill. Indeed, the department chairman is otherwise described as an "ideal chairman," an "aggressive, dynamic leader" who should be given greater authority. Nor can there be any indication of pattern or practice or "ethnic cleansing," or systemic unfairness, without opening up, for all fifteen hospitals, the background and institutional history of every physician, minority and non-minority, discussed in each report. The unsupported possibility that this discovery might turn up something does not justify either the inevitable intrusion into confidential matters nor the resultant expansion of discovery.

The next three motions can be determined without extended analysis. The only confusion arises from the rhetoric engaged in by both sides. A carefully drafted request and a carefully drafted response should obviate the necessity for disputes such as these. The first of these three motions asks for peer review records of Swedish Covenant Hospital anesthesiologists. The responses to that motion and the second motion are that defendants have produced or are producing all documents responsive to the request: "There are no other documents fitting plaintiff's requests." Plaintiff is entitled to production of the documents requested and defendants have responded by representing that they have produced all such documents. The motion to compel is, for now, denied as moot. If plaintiff believes that there are

documents that may be responsive to her request but that defendants have not produced she should so specify in another request.

The second motion of the three seeks Swedish Covenant Hospital to provide letters of reference and governmental reports "Regarding Dr. Vakharia," but in the body of the motion expanded to include all the anesthesiologists. Plaintiff is entitled to those documents. *Memorial Hospital for McHenry County*, 664 F.2d 1058 (7th Cir. 1981). The defendants respond by stating that they have produced "[a]ll of those documents" with respect to governmental reports, and they indicate that they have produced all letters of reference documents. If they have, they should expressly so state. If they have not, they should produce the remaining documents or explain what has not been produced and why.

The third of the three motions asks for more adequate responses to interrogatories from Dr. Wender and Dr. Blancato. Plaintiff's complaint is that the doctors did not specify in detail the information requested. The interrogatories and their answers are reflective of the limitations upon interrogatories as a form of discovery. The doctors were involved in the survey for a limited time over four years ago. The disputes leading to his lawsuit obviously have been very much on plaintiff's mind since then, but that is not so for the doctors. The answers appear to reflect their best recollection at the time they responded. Perhaps they can recall more if they review the transcripts of the ad hoc committee hearing. Perhaps they will have recollections of particular cases upon review of the patient records. Perhaps they will have little or no recollection of particular cases but can now point out the matters that would lead them to certain

conclusions. And perhaps the basis of various opinions are forever erased from memory by the passage of time. Interrogatories are, however, an imperfect vehicle for uncovering layers of memory. The motion is denied.

Finally, we have two motions by plaintiff, one to produce documents designated as Group I and the other designated Group II. As in a previous motion, the parties have engaged in extensive memoranda to indulge in complaints about each other and to argue over "pertinent" and "relevant." From the responses to most of the requests in Group I it seems apparent that defendants have used "pertinent" and "relevant" in the same sense as "responsive to the request," and we will treat them as the same unless defendants specify (as they must do if we are in error) that they used those words in a different sense. We would have thought that any misunderstanding on that matter would have resolved at a 12(k) conference, if not before.

Given this court's perception, only a few of the Group I disputes require consideration. We are not given any reason why Request 26 for minutes of the Credentials Committee for 1985-1987 should not be produced. They should be. 1985 has been benchmark for some matters and it is long before Dr. Loeber appeared on the scene. This court believes there is justification for asking for documents pertaining to modifications or rejections relating to physicians on staff, and we direct that these be produced (Request 17), although the documents are marginal at best. We leave until later our comments on discovery relating to the hospital generally, beyond the anesthesiologists. We understand the responses to Requests 24, 62, 103, 105, 125 and 127 to cover all

documents covered by the requests. If we are in error, defendants have an obligation to so advise. The responses to Requests 52 and 53 are indeed incomprehensible and should be clarified.

The same ground rules apply to Group II documents. *See* Requests 34, 44, 45, 46, 48, 59, 85, 89, 92 and 93. In her reply plaintiff refers to "privilege files." Since we do not understand what those are supposed to be, and defendants have had no opportunity to comment, we deny that request for now. We think that Requests 9, 13, 14, 18 and 19 are too broad both in time period and scope. This case relates to an anesthesiologist, not to physicians generally. We have allowed production relating to any terminations or restrictions, and that is enough. Request 15 is too broad in time period. Defendants are cautioned, however, that they cannot seek to rely on employment information from 1990 unless they are willing to share the related documents for that period. Defendants should respond to Request 22 on the basis of the clarification set forth in plaintiff's reply. We fail to see how the manner of Dr. Saxena's appointment and departure can be germane to anything. Requests 27 and 28 are denied. Finally, we do not know what the parties discussed and agreed upon at the 12(k) conference relating to Request 121, or what would be responsive according to plaintiff's present reading of Request 121 and not yet produced. We therefore defer any ruling.

s/ James B. Moran
JAMES B. MORAN,
Chief Judge, U.S. District Court

Sept. 14, 1993.

APPENDIX B — MEMORANDUM AND ORDER OF THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS, EASTERN DIVISION DATED JUNE 8, 1993

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ILLINOIS EASTERN DIVISION

No. 90 C 6548

USHA VAKHARIA, M.D.,

Plaintiff,

vs.

SWEDISH COVENANT HOSPITAL, et al.,

Defendants.

MEMORANDUM AND ORDER

Before us now are three motions by plaintiff. In her first motion she asks the court to reconsider its ruling dismissing her discrimination claims against several defendants named for the first time in her amended complaints (detailed in count V of her second amended complaint). In her second motion she asks the court to reconsider its dismissal of portions of her antitrust claim (detailed in count VI). In her third motion, submitted pursuant to Fed.R.Civ.P. 56(f), plaintiff asks for leave to conduct depositions of certain individuals prior to responding to defendants' motion for summary judgment. Her first and third motions are granted in part and denied in part. Her second motion is denied.

Appendix B

DISCUSSION

Count V

This court has dismissed plaintiff's Title VII claims against several defendants because plaintiff failed to charge them within the applicable limitations period. *See Vakharia v. Swedish Covenant Hospital*, 90 C 6548, slip op. at 6 (N.D.Ill. March 31, 1993). Invoking the doctrine of equitable tolling, plaintiff argues that she should not be barred from suing the dismissed defendants because they participated in various administrative proceedings at the hospital and thereby misled her into thinking that her medical staff privileges might be restored. Her argument is unpersuasive. Although, as a general rule, the doctrine of equitable tolling is applicable to Title VII cases, *Zipes v. Trans World Airlines, Inc.*, 455 U.S. 385, 393 (1982), the decision by potential adversaries in a Title VII case to participate in administrative proceedings does not trigger it. *International Union of Electrical, Radio & Machine Workers, AFL-CIO Local 790 v. Robbins & Myers, Inc.*, 429 U.S. 229, 236 (1976); *Lever v. Northwestern University*, 979 F.2d 552, 556 (7th Cir. 1992), *pet. for cert. filed*, 61 USLW 3732 (April 8, 1993).

In its order of March 31, 1993. this court noted that plaintiff's amended complaints were filed within the applicable limitations period to the extent that they alleged a claim under 42 U.S.C. §1981 against members of the hospital's board of directors for impeding plaintiff's efforts to form new contracts with patients. *Vakharia*, 90 C 6548, slip op. Plaintiff now indicates that two defendants who were named in the amended complaints, Arthur Peterson and

Edward Cucci, were dismissed erroneously from count V because she neglected to identify them as board members. Because defendants do not deny that Peterson and Cucci were board members, and because both have received adequate notice of the §1981 claims against them, plaintiff's motion to reconsider must be granted with respect to them. However, plaintiff may proceed under count V against them only to the extent that they may be liable under §1981, along with other named members of the board of directors, for impeding her efforts to form new contracts with patients.

Count VI

In the same memorandum and order this court held that plaintiff could proceed with part of her antitrust claim under section 1 of the Sherman Act. Several distinctions were drawn, however, that significantly restricted the scope of her surviving claim. *Id.* at 17-20. Most of the defendants were dismissed from count VI because they could not be considered co-conspirators, and plaintiff's claim was a conspiracy claim. And, while the portion of the claim based on the hospital's decision to terminate plaintiff was spared, the portions of her claim based on the hospital's other acts, including its establishment of a "multi-tiered" system for assigning patients, were dismissed. Now plaintiff asks the court to allow her to pursue her antitrust claim against all defendants named in the second amended complaint and, in addition, she tentatively seeks permission to pursue an independent antitrust claim based on the multi-tiered system for assigning cases. As this court has indicated, the results plaintiff desires are foreclosed by several Supreme Court and Seventh Circuit decisions (cited in the March 31, 1993

order). Intra-corporate dealings of the sort alleged cannot constitute conspiracies, and claims premised on the restriction of competition within a single hospital are not cognizable under the federal antitrust laws.

Perhaps the hospital's establishment of a multi-tiered system of assigning cases was, as plaintiff says, a "step in the process that culminated in Dr. Vakharia's total loss of privileges." Even if true, however, that fact cannot justify granting plaintiff's motion to reconsider the partial dismissal of count VI, although it might constitute probative evidence concerning her antitrust claim based on the hospital's hindering her efforts to find placement elsewhere. Because trial is a long way away, the court need not resolve that evidentiary issue at this time.

Motion Pursuant to Fed.R.Civ.P. 56(f)

Defendants have filed a motion for summary judgment on the first four counts. That motion is supported by three affidavits, from Dr. James B. McCormick, president of the hospital; Dr. Nancy Loeber, former chairman of the anesthesia department; and Dr. Alan Rogin, chairman of the *ad hoc* hearing committee. The thrust of that motion is that Dr. Loeber was brought in because of concerns about the quality of anesthesiological services, that she performed a performance audit of plaintiff and had concerns about a number of cases, that those concerns were not satisfactorily resolved but in the meantime plaintiff chose to go on part-time status, that thereafter the department was reorganized so as to have senior anesthesiologists for the more serious cases and junior anesthesiologists for the less

serious cases, that (apparently) plaintiff was classified by Dr. Loeber as a junior anesthesiologist, that thereafter plaintiff sought to return to full-time status as a senior anesthesiologist, that Dr. Loeber then determined that the caseload would not support another full-time anesthesiologist in either classification and that plaintiff had not demonstrated sufficient proficiency for "senior" cases, that plaintiff objected, and that led to a review of the performance of Dr. Vakharia and ultimately of the entire department. That review began with Dr. Loeber, who came up with approximately 66 cases of plaintiff's in which Dr. Loeber believed the total care had been in one way or another inadequate. Plaintiff then requested the Medical Executive Committee (MEC) for return to full-time status. The MEC appointed a committee which considered the situation and reported to the MEC. The MEC concluded that another full-time position was not justified, but did not take a position on the quality-of-care issues. It decided, rather, to retain an independent consultant to evaluate plaintiff's work, and later that review was expanded to include the entire department. It was performed by two doctors selected by the ASA and under the auspices of that organization. The review, as it pertained to plaintiff, included 43 cases involving major complications and 24 randomly selected cases, material submitted by plaintiff, and various interviews at the hospital, including extensive interviews of plaintiff. The report, issued in June 1989, included the recommendation that the medical staff privileges of Dr. Vakharia, as well as those of two other anesthesiologists, should not be renewed.

The hospital then gave plaintiff the option of resignation or summary suspension. Since plaintiff did not resign she

was summarily suspended, and that triggered a hearing before an *ad hoc* committee of the MEC consisting of five physicians and a hearing officer. Attorneys were involved, for the most part, only in an advisory capacity. The hearings spanned 17 days and generated 3130 pages of testimony and argument, 38 exhibits from the hospital and over 200 from plaintiff. Dr. McCormick, Dr. Loeber, Janice Anderson and Dr. Wender (one of the ASA reviewers) testified at length, and plaintiff had 21 witnesses. The committee upheld the suspension and the MEC adopted the recommendation on May 9, 1990. That decision was appealed to the hospital's board, which appointed a review committee. That committee reviewed the lengthy submissions and the record and, on September 7, 1990, issued a 21-page report recommending that the MEC decision be adopted by the board, and it did so on September 12, 1990.

We recite the defendants' summary judgment contentions at some length because they have a bearing on the pending motion. Plaintiff wants to take the depositions of at least 19 persons prior to responding to the motion. Defendants do not see why any are necessary but, in any event, they should not extend beyond the three affiants. We begin by noting that plaintiff is entitled to a reasonable opportunity to conduct necessary discovery on her claims prior to responding to the summary judgment motion. At the same time, we note that this court has the obligation, pursuant to Rule 26, to control discovery so that it is not unduly burdensome and expensive. That obligation has been increasingly emphasized of late and concerns about discovery abuse underlie both the Civil Justice Reform Act direction that district courts adopt plans and the proposed amendments

to the Federal Rules of Civil Procedure. Those proposed amendments, specifically Rule 30, would establish a maximum of ten depositions by a party as the norm for civil cases and that a witness once deposed should not normally be deposed again. Here the plaintiff seeks 19 depositions just for starters, including depositions of witnesses who were questioned at length in the *ad hoc* committee hearing. It is an ambitious program to depose virtually everyone who had or may have had some relationship to the process during which plaintiff's practice was curtailed and (considerably more significant in terms of the amount in controversy) thereafter suspended. And it goes too far in light of the position advanced by the defendants and the rather weak justifications advanced by plaintiff.

The motion relates primarily to the employment discrimination claims. Defendants say that plaintiff's troubles up to the suspension time stem from decisions made by Dr. Loeber. Janice Anderson was, it appears conceded, involved in securing information leading up to some of those decisions. Dr. McCormick was also knowledgeable about that period. Dr. Loeber and Dr. McCormick are affiants and plaintiff may depose them, but with due regard for the fact that they previously testified before the *ad hoc* hearing committee. Janice Anderson also testified there and plaintiff has presented no substantial reason why she must be questioned again. Plaintiff has presented no substantial reason to question that Dr. Loeber was the ultimate decisionmaker during that period or that others tainted the information upon which Dr. Loeber claimed she replied. We therefore see no reason to depose Karen Filopowski at this time. Dr. McCormick was familiar with hospital needs during

that period. Judith Borenstein participated in the May 7, 1988 discussion of needs and assisted in providing information for the ASA review. We think plaintiff is entitled to depose her, but we are unconvinced that there is sufficient justification, for now, to take the depositions of Dr. Paulissian (who, after all, testified for plaintiff before the *ad hoc* committee) regarding the May 7, 1988 meeting or for any other purpose.

Plaintiff seeks the depositions of Dr. Blancato, Dr. Vacanti and Dr. Wender. Defendants contend that the ASA report was a significant matter in the ultimate suspension. Plaintiff is entitled to depose Dr. Blancato. We are not persuaded that the deposition of Dr. Vacanti is needed. He may have appointed the other two to be the surveyors, but the issues here relate to Dr. Vakharia, not ASA in general. Plaintiff has already, apparently, explored general procedures in her questions to Dr. Wender at the *ad hoc* committee hearing, and those can be explored adequately with Dr. Blancato as well. We do, moreover, permit the deposition of Dr. Wender. Defendants contend that plaintiff deliberately failed to explore quality-of-care issues with Dr. Wender. Because she was acting *pro se* at the time, we think her attorney is now entitled to make that inquiry.

Five physicians comprised the *ad hoc* committee. One, Dr. RPogin, is an affiant, and his deposition may be taken. She may also depose two of the four others, thus giving her access to a majority of a unanimous committee. We see no reason, however, to depose counsel (Callahan and Scott), absent some compelling evidence that they influenced the result and acted other than as attorneys. Further, if, as plaintiff

claims, Scott prevented her from having witnesses testify she has knowledge about that matter, she can, herself, bring it to the attention of the court, and, if the hearing officer, Hannafan, was unfair, plaintiff can point that out from the 3130 pages of transcript. Finally, we are not persuaded that the depositions of Dr. Shah, Dr. Yelda or Dr. Larson have been reasonably justified.

We are somewhat uncertain how plaintiff is proceeding. Ordinarily depositions are for the purpose of getting information from non-parties or pinning down parties. It is the rare plaintiff who expects the defendants, or those allegedly in league with them, to make the case for her when the charges are of unsavory conduct, unless plaintiff has evidence to present to the defendants that requires an admission. Here the claims are of purposeful discrimination against her, claims that plaintiff has consistently presented for a number of years. To the extent she has personal knowledge of these claims, she can present that evidence by affidavit. To the extent she has evidence from others, she can also present it by their affidavits. Even with such evidence she must still address, now or ultimately, the quality-of-care issues raised by defendants.

Defendants are now scheduled to complete production of documents by June 23, 1993. The permitted depositions should be completed within the following 60 days, or by August 23, 1993. Plaintiff shall file her responsive brief by September 23, 1993 and defendants shall file their reply brief by October 14, 1993.

Appendix B

Liability of Defendants in Their Individual Capacities

At a recent status conference the parties expressed some confusion about the implications of this court's March 31, 1993 order on the personal liability of some of the defendants. Apparently the order requires some elaboration.

As this court noted in its opinion of May 22, 1991, a defendant may be liable under Title VII and §1981 even if the defendant is not the plaintiff's employer. *Vakharia v. Swedish Covenant Hospital*, 765 F.Supp. 461, 463 (N.D.Ill. 1991). The same is true, presumably, of defendants sued under the ADEA, though the issue has not been raised in this case. Under all three statutes, if a defendant discriminatorily impedes a person's access to employment opportunities with third parties, the defendant may be liable. That much follows from the May 22, 1991 memorandum and order. The question the parties now raise is whether such a defendant may be liable in his or her individual capacity when the defendant was acting as an agent for someone else. The answer is yes.

Under the ADEA, Title VII and § 1981, individuals may be held personally liable for civil rights violations they commit while working as agents of larger institutions, provided that their individual liability is based on individual acts distinct from institutional policy set by their superiors. When a manager at a company terminates an employee on account of that employee's race or age, the company is liable,[1] as is the manager, unless the manager's decision was

1. When a private company is involved, the acts of an employee can create §1981 liability for an employer. *See Gatlin v. Jewel Food* (Cont'd)

mandated by company policy set by someone else. Thus, decisionmaking employees who discriminate on the basis of age may be held liable in their individual capacities under the ADEA. *See e.g., Strzelecki v. Schwarz Paper Co.*, 92 C 6668, slip op. (N.D.Ill. May 27, 1993); *House v. Cannon Mills Co.*, 713 F.Supp. 159 (M.D.N.C. 1988); *Price v. Marshall Erdman & Associates, Inc.*, 966 F.2d 320, 324 (7th Cir. 1992) (discussing personal liability of decisionmaker). Decisionmaking employees also may be held liable in their individual capacities under Title VII. *See Bridges v. Eastman Kodak Co.*, 800 F.Supp. 1172, 1180 (S.D.N.Y. 1992); *Robinson v. Jacksonville Shipyards, Inc.*, 760 F.Supp. 1486, 1527 (M.D.Fla. 1991); *Gaddy v. Abex Corp.*, 884 F.2d 312, 318-19 (7th Cir. 1989) (discussing personal liability of decisionmaker); *E.E.O.C. v. Vucitech*, 842 F.2d 936, 942 (7th Cir. 1988) (discussing personal liability of decisionmakers). And decisionmaking employees may be held liable under §1981. *Al-Khazraji v. Saint Francis College*, 784 F.2d 505, 518-19 (3rd Cir. 1986), *aff'd*, 481 U.S. 604 (1987); *Musikiwamba v. ESSI, Inc.*, 760 F.2d 740, 753 (7th Cir.

(Cont'd)

Stores, 699 F.Supp. 1266, 1268-69 (N.D.Ill. 1988); *Montgomery v. Campbell Soup Co.*, 647 F.Supp. 1372, 1378 (N.D.Ill. 1986). However, when a municipal agency is involved, the municipal employee's isolated acts will not subject the municipal employer to liability under §1981 — at least as §1981 existed prior to the Civil Rights Act of 1991 — unless the employee was following established policy. *Jett v. Dallas Independent School District*, 491 U.S. 701, 735-36 (1989); *East v. City of Chicago*, 719 F.Supp. 683, 688 (N.D.Ill. 1989). In other words, under *Jett*, *respondeat superior* claims against municipalities are void under §1981, just as they are void under §1983. *See Monell v. Department of Social Services of City of New York*, 436 U.S. 658, 690-91 (1978).

1985); *Manuel v. International Harvester, Co.*, 502 F.Supp. 45, 50 (N.D.Ill. 1980).

Courts around the country seem to be in complete agreement with respect to personal liability of decisionmaking employees under §1981. As indicated, this court believes that individual defendants should be treated the same way under the ADEA and Title VII as they are under §1981. This court recognizes, however, that other courts have treated ADEA and Title VII defendants differently. For example, in *Miller v. Maxwell's International, Inc.*, 61 USLW 2649 (9th Cir. 1993), the Ninth Circuit held that a supervisor could not be held personally liable under the ADEA for a discriminatory decision made on behalf of an employer corporation. In this district, Judges Duff and Aspen have reached a similar conclusion with respect to Title VII. *See Weiss v. Coca-Cola Bottling Co. of Chicago*, 772 F.Supp. 407, 411 (N.D.Ill. 1991); *Pommier v. James L. Edelstein Enterprises*, 816 F.Supp. 476, 481 (N.D.Ill. 1993). Judge Duff's opinion reflects the reasoning of the courts that have rejected personal liability of corporate agents: the only remedies available under Title VII, he points out, are remedies that "an employer, not an individual, would generally provide."[2] *Id.* While granting the premise, this court respectfully disagrees with the conclusion.

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2. Judge Duff was describing Title VII as it existed prior to the Civil Rights Act of 1991. As noted previously, the 1991 amendments to Title VII and §1981 do not apply to this case. However, if the amendments did apply, Judge Duff's argument would lose virtually all of its force, since the 1991 amendments allow for full compensatory damages — not just back pay — as well as punitive damages. *See Bridges*, 800 F.Supp. at 1180.

Appendix B

Title VII always has served two purposes: to compensate the victims of discrimination (at least with back pay, if not with full compensatory damages), and to deter discrimination in the future. *Albemarle Paper Co. v. Moody*, 422 U.S. 405, 417-418 (1975). To conclude that personal accountability of supervisory employees is unnecessary to reinstate victims or to award them their back pay is to neglect Title VII's broader goal of eradicating discrimination.

Moreover, while ordinarily personal liability is not of great consequence either to the plaintiff or to the individual defendant (and perhaps that is why the issue is seldom considered), there are cases, like *Vucitech*, 842 F.2d 936, in which the defendant company goes bankrupt and the plaintiff is forced to seek recovery from the supervisory employees who committed the discriminatory acts. As this court noted in *Strzelecki*, if the people who make discriminatory decisions do not have to pay for them, they may never alter their illegal behavior and the wrongdoers may elude punishment entirely, while the victim may receive no compensation whatsoever. That outcome is incompatible with the broad remedial purposes of the ADEA and Title VII, which were intended to provide all "necessary relief" and to ensure "complete justice." *Albemarle Paper Co.*, 422 U.S. at 418.

CONCLUSION

Plaintiff's motion to reconsider the court's partial dismissal of count V is granted in part and denied in part. Her motion to reconsider the court's partial dismissal of count

Appendix B

VI is denied. Her motion pursuant to Fed.R.Civ.P. 56(f) is granted in part and denied in part.

s/ James B. Moran
JAMES B. MORAN,
Chief Judge, U.S. District Court

June 8, 1993.

Supreme Court, U.S.
FILED
MAY 17 2000
CLERK

(3)

No. 99-1481

In the
SUPREME COURT OF THE UNITED STATES

USHA VAKHARIA, M.D.,
Petitioner,

v.

SWEDISH COVENANT HOSPITAL, AMERICAN SOCIETY OF ANESTHESIOLOGISTS, et al.,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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THE RESPONDENTS' "QUESTIONS PRESENTED" AND "STATEMENT OF THE CASE" IS AN ABUSE OF THE RULES OF THIS COURT

Respondents' brief in opposition reflects the central problem of the instant case, a case decided by summary judgment without the benefit of any jury finding. Nearly every statement of alleged fact contained in the respondents "statement of the case" was contested by a specific response and documentary evidence, contesting virtually every assertion (Ap. Br. SA2, SSA1).

The rules of this court do not permit a responding party to present as "the facts" that which it would have a trier of fact believe to be more probably true. Under Rule 14 (g) the petitioner is to set forth the facts "material to consideration of the issues presented for review." The petitioner has done that (Pet. 2-14). This case comes to this court after a summary judgment. After summary judgment a reviewing court is to consider all reasonable facts and inferences in the record most favorable to the non-movant, *Hunt v. Cromartie*, 119 S.Ct. 1545, 1551-2 (1999). Under Rule 15(2), "brief in opposition should address any perceived misstatement of fact...that bears on what issues properly would be before the court if certiorari were granted. Counsel are admonished that they have an obligation to the Court to point out in the brief in opposition, and not later, any perceived misstatement made in the petition." The respondents have simply ignored that injunction and have presented a statement of the case based on their own affidavits the factual contents of which were hotly contested.

The respondents have seized upon a weakness in the review process which, if the court permits, is subject to exploitation by the unscrupulous. The record on appeal is not submitted with a petition for writ of certiorari. As a consequence neither party is required to back their statements of fact with citations to the record, and the

court relies on their good faith to recite only those which are truthful and relevant. The viciousness of respondents' practice, when this court is inundated with numerous petitions but can take only a small percentage, is unquestionable. The efficacy of this court's review procedure depends on a level of professional integrity wholly lacking on the part of respondents, who have ignored the petitioner's statement while submitting their own spurious statement with citations to the missing record in order to give it an air of verisimilitude. Now the petitioner is faced with a dilemma, does she sit down and go fact by fact to demonstrate where the truth lay? If she does, and this court had the time or patience to wade through the reply, then what the petitioner had to say would itself be unverifiable. Moreover, this court does not sit to resolve issues of fact. These rules have as their purpose the presentation of the case in an orderly manner for reasoned consideration. This smokescreen is an insult to the intelligence of the court and a practice which, if permitted, would serve as an open invitation to defend summary judgments by obfuscation of the issues and creating "facts" not relevant to the issues presented. The respondents have not denied any of the facts as presented by petitioner, and should not be permitted to avoid review by this practice, a tacit admission that the relevant facts would demonstrate the error of the decision.

Similarly under "Questions Presented," a parody of what is called for by Supreme Court Rule 14 (a) is offered by respondents. The very first "question" provided is pure and simple "spin." The peer review committee did not terminate the plaintiff's hospital staff privileges, nor was its decison "based on unrebutted, unbiased, and credible evidence" See the petitioner's statement of the case. The question is not simply whether the "plaintiff failed to present sufficient evidence of pretext" but whether it is a proper summary judgment standard for a federal court to defer to the judgment of a hospital "peer review" commitee when evidence of discrimination and comparative evidence

were excluded. Questions II through V are also similarly presented, voluminous discovery was not allowed, and dispositive motions were not fully briefed; no hearsay, self-interested conclusions, or any unsupported fact assertions were identified by anyone.

THE FAILURE TO CONSIDER COMPARATIVE EVIDENCE IS CRUCIAL

One of the false facts on which respondents' argument hinges is that the ad hoc committee excluded the issue of discrimination because petitioner did not respond to its request for a statement as to the proper scope of the hearing (Resp. 16). No such finding was made by either court nor given as a basis for ignoring comparative evidence. Moreover, petitioner denied this fact and offered three letters sent to the committee and its attorney (DK#539 p.71) as evidence.

Respondent's statement (Resp. 16) that "nothing precluded Dr. Vakharia or her experts from reviewing *any record of her choosing* (emphasis added) with Dr. Wender (or Dr. Loeber) and taking issue with him at the hearing" is false. Neither Dr. Vakharia nor her expert witnesses, particularly Dr. Floyd Heller, were allowed to see the records of other anesthesiologists to demonstrate the disparity of treatment as well as the falsity of the testimony of Drs. Wender and Loeber (DK#572 pp.131-41). These records were only produced by court order two and a half years after the hearing (DK#202). Once allowed to review these records, Dr. Heller, Associate Professor of Anesthesiology, Rush-Presbyterian St. Luke's Medical Center, repudiated the ASA report, concluded that the medical charts provided to the ASA on the three "senior" (white native-born American) anesthesiologists demonstrated more serious problems with anesthesia care than any of the problems allegedly related to Dr. Vakharia's care, and their charts evidenced many, if not all, of the technical or judgmental errors assigned by

Wender or Loeber to Dr. Vakharia (DK#497). Dr. Vakharia's case is a discrimination case, and the cases which would demonstrate the disparate treatment were not allowed to be obtained or presented.

There was much more. Unquestionably the committee was on notice that Dr. Vakharia asserted that discrimination was the real basis for the charges yet they expressly instructed her not to present any evidence of discrimination or to question any witness on the work of other physicians (DK#572 p.131-41). As this court said in *Harte Hanke Communications, Inc. v. Connaughton*, 491 U.S. 657, 692 (1989), a libel case, "Although failure to investigate will not alone support a finding of actual malice (citation), the purposeful avoidance of the truth is a different category."

The respondents argue that the Court of Appeals analysis is not in conflict with *Bolt v. Halifax Hospital Medical Center,* 891 F.2d 810 (11 th Cir.), *cert. denied* , 495 U.S. 924 (1990); *Miller v. Indiana Hospital*, 843 F.2d 139 (3rd Cir., 1988), *cert. denied,* 488 U.S. 87 (1990) and *Brown v. Presbyterian Health Care Service*, 101 F.3d 1324 (10th Cir. 1996), *cert. denied,* 520 U.S. 1181 (1997) as there was no evidence of dishonesty, including direct financial conflicts of interest among members of the peer review committee (Resp. 19). This distinction does not exist. In this case, three witnesses testified *at the hearing* that the main witnesses of respondents, Drs. Wender and Loeber, were lying to the committee. Speaking of Wender's conclusions, Dr. Heller testified *at the hearing* that he "became very suspicious because I don't know how he could glean from those records and arrive at those opinions when you just look at the charts and the medical records" (DK#572 pp.2524-25); he noted the "inconsistencies of Dr. Wender" (DK#572 p.2556); he felt that "the peculiar statements he made were prejudicial in nature and not substantiated in the literature or in the cases that I witnessed." (DK#572 p.2551). He testified that Dr.

Wender's testimony regarding failed regional anesthesia was so insupportable that Wender would never have been able to get it past a panel of anesthesiologists (DK# 572 pp.2575-77; DK# 578 pp.169-70, 294-95).

Dr. Heller compared the testimony of Dr. Loeber to the medical records, and his affidavit stated (DK# 497)

> 22. Attached hereto as Group Exhibit A are listings of statements made by Dr. Loeber regarding the condition and treatment of these patients which are contradicted by the medical records pertaining to the patients involved.
>
> 23. The foregoing matters would not involve matters of medical judgment but are matters of fact.
>
> 24. The significance of virtually all of the entries in the medical records would be understandable to any physician who is in practice and who is attempitng to understand them with reasonable diligence.
>
> 32. ...After listening to Dr. Wender's testimony and the Committee's conduct at the time, and on March 8, 1990, when I testified, I had concluded that the hearing was merely a sham and that any futher testimony from me or anyone else would not in any way affect the predetermined result...

Dr. James O'Brien, Chief of Anesthesiology at Central Du Page Hospital, testified *at the hearing* that in her written comments, Dr. Loeber made "several rather dogmatic statements that are basically not true" (DK#572 p.2678); "no basis in reality" (DK#572 p.2641); "had no basis in fact" (DK#572 p.2647) and another charge was "baseless" (DK#572 p.2659). Dr. O'Brien testified that Dr. Wender's testimony had been given as if he had not read the charts but simply relied on the case summaries supplied by the hospital (DK#572 pp.2677-787, 2718). Despite such

testimony, while the committee was willing to allow the hospital witneses to offer perfunctory conclusions as to the care rendered by the "seniors" (white native-born anesthesiologists) without any supporting facts or medical records, it was unwilling to allow comparative testimony from Dr. Vakharia or her experts (DK#572, p. 186, 198, 202, 227, 233, 258, 263, 309, 313, 326, 357-58, 1167).

Two of the committee members were physicians in a case with complications and in which their own care was subject to question. One of these doctors also cut a patient's ureters in a case offered by the hospital to show the petitioner's charting problems. The fee statements of the hearing officer obtained after the case was filed showed *ex parte* conferences with the hospital attorneys during the period in which the hearing was held as well as the preparation of the final report and the committee members testified that they had no input into the preparation of the report (DK#584, SCF 4300, 4298, 4294, 4291, 4288, 4285). This makes the proceedings presumptively unfair, *Walker v. City of Berkeley,* 951 F.2d 182, 184 (9th Cir. 1991).

Another proffered distinction by respondents is that because *Miller*, *Bolt* and *Brown* are anti-trust cases, not employment discrimination cases, they cannot present a conflict (Resp. 18-19). This suggested rationale is another reason for this court to take this case. This distinction is not valid because at the very heart of a discrimination case is comparative evidence. Respondents' argument should be resolved by this court so that the lower courts, in dealing with discrimination cases, will have precedential guidance on this issue. The argument, now advanced in this case for the very first time (Resp. 19), that the hospital is immune under the Health Care Quality Improvement Act, 42 U.S. C. Secs. 11111(a) and 11112(a) is for that very reason not permissible.

Another false factual statement is offered, namely that "Dr. Vakharia and her expert sandbagged the

Committee and the Hospital by refusing to addess her cases at all" (Resp. 16). Petitioner will not rest by simply stating that she had no obligation to demonstrate the lack of *bona fides* to the committee. *Miller*, 891 F.2d at 144, *Bolt*, 891 F2d at 817, 820, and *Brown*, 101F.3d at 1333-34 held that testimony, including that of a physician, bearing on the good faith of the hearing given subsequent to that hearing is not a bar to presentation in the subsequent case. Not only did seventeen physicians at the hospital testify that they would have no hesitancy in Dr. Vakharia treating themselves or their families,[1] but two expert witnesses, Drs. Heller and O'Brien tesified that Dr. Vakharia met the applicable standard of care and with respect to specific cases pointed out where Dr. Wender and Dr. Loeber had made false charges (DK#572 pp.1998-99, 2009, 2503-92, 2600-01, 2604, 2605, 2607, 2661, 2675, 2677). So also did Dr. Nennhaus (DK# 572 p.1986). The petitioner herself submitted a written case-by-case analysis refuting all of Dr. Loeber's and Dr. Wender's complaints with citations to medical literature and standards in support. (DK#503 ex.41A/41B). The assertion (Resp. 18) that Dr. Heller declined the committee's invitation to return for another day of testimony is another distortion of the record. The committee gave plaintiff 3 1/2 days to present her case in March 1990, Dr. Heller appeared on one of those days, testified until 5:00 p.m. and was willing to continue into the evening but the committee decided to adjourn. The committee gave him two days on which he could appear, but because of his own work, he could not return on those days (DK#497 p. 33). The petitioner asked on a number of occasions for an extension of the hearings and was refused (DK#503 ex.42).

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[1]DK #572 pp. 1841, 1844, 1855, 1875, 1877, 1882,, 1895, 192, 190, 1921, 1930, 1934, 1986, 2005, 2008, 2121, 2151, 2164, 2204, 2206, 2210, 2211, 2214, 2221, 2248, 2249, 2250, 2258, 2272, 2297, 2299, 2320, 2321, 2322, 2329, 2349, 2354, 2389, 2409, 2436, 2488, and 2511

THE WITNESSES WHO WERE NOT ALLOWED TO BE DEPOSED WERE CENTRAL TO THE ISSUE OF GOOD FAITH

As set forth on page 8 of petitioner's statement of the case, the medical records section of that report was of critical importance, and the testimony of Drs. Wender and Blancato indicated that they, the purported investigators, did not write this portion of the report (DK#539, p.178). The complaint alleged a conspiracy between the ASA and the hospital to eliminate foreign-born medical graduates from the hospital staff through a sham peer review. The petitioner sought to depose two ASA personnel, Dr. Charles Vacanti and attorney Michael Scott, persons who would have drafted the report even though they had not reviewed any medical records. While the court has discretion to control discovery, the court's denial of leave to take the depositions of Dr. Vacanti and Mr. Scott on the basis that they "were largely irrelevant to the issues in this litigation" is an abuse of that discretion, particularly when the court enters summary judgment thereafter with the issues as set forth in the complaint.

THE FAILURE TO CREDIT PETITIONER'S 12M STATEMENT GOES BEYOND APPLICATION OF LOCAL RULES

Respondents' assertion that the petitioner had failed to challenge the "finding" of Judge Moran that her 566 paragraph 12M statement was "replete with hearsay, self-interested conclusions and unsupported fact assertions," is simply false. As noted by petitioner (Pet. App. 20), the respondents failed to respond even by way of objection to this 12M statement. This statement was used not only in connection with the respondent's moton for summary judgment but petitioner's motion for summary judgment. Assuming *arguendo* that some paragraphs had hearsay or self-serving statements, if something which is hearsay or a self-interested conclusion is not objected to, it

is deemed admitted. The court did not specify any facts which it felt were proper assertions and which were not. The petitioner cited where in the record each fact was derived. Local Rule 12N is an extension of Federal Rule of Civil Procedure 56(e) which requires a specific factual response by affidavit or other proof.

THE PROPRIETY OF ALEXANDER WAS RAISED

The petitioner brought the issue of the propriety of *Alexander v. Rush North Shore Medical Center,* 101F.3d 487 (7th Cir., 1996), *cert. denied,* 522 U.S. 811 (1997) in light of the language of Title VII and the ADEA as well as this court's decision in *Robinson v. Shell Oil Co.*, 519 U.S. 337 (1997) to attention to the trial court and the Court of Appeals. For example, quoting from petitioner's appellate brief dealing with *Alexander*, p. 17, "Title VII and the ADEA apply not only to 'employees' but also 'applicants for employment' and likewise forbid retaliation against 'applicants for employment' 42 U.S.C. Sec. 2000e-3(a) and 29 U.S.C. Sec, 623(d); *Robinson v. Shell Oil Co.,* 519 U.S. 337 (1997)." Respondents reliance on *Nationwide Mutual Ins. Co. v. Darden* , 503 U.S. 318 (1992) is misplaced. *Darden* is an ERISA case, and this court has expressly stated that "examples of non-Title VII cases using the term 'employee' to refer to a former employee are largely irrelevant, except to the extent they rebut a claim that the term 'employee' has some intrinsically plain meaning," *Robinson, Id.* at 344. The Court of Appeals' analysis under Section 1981 was flawed by its decision that its "inquiry was necessarily limited to the evidence that the committee actually had at its disposal."

Respectfully submitted,

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